

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12758

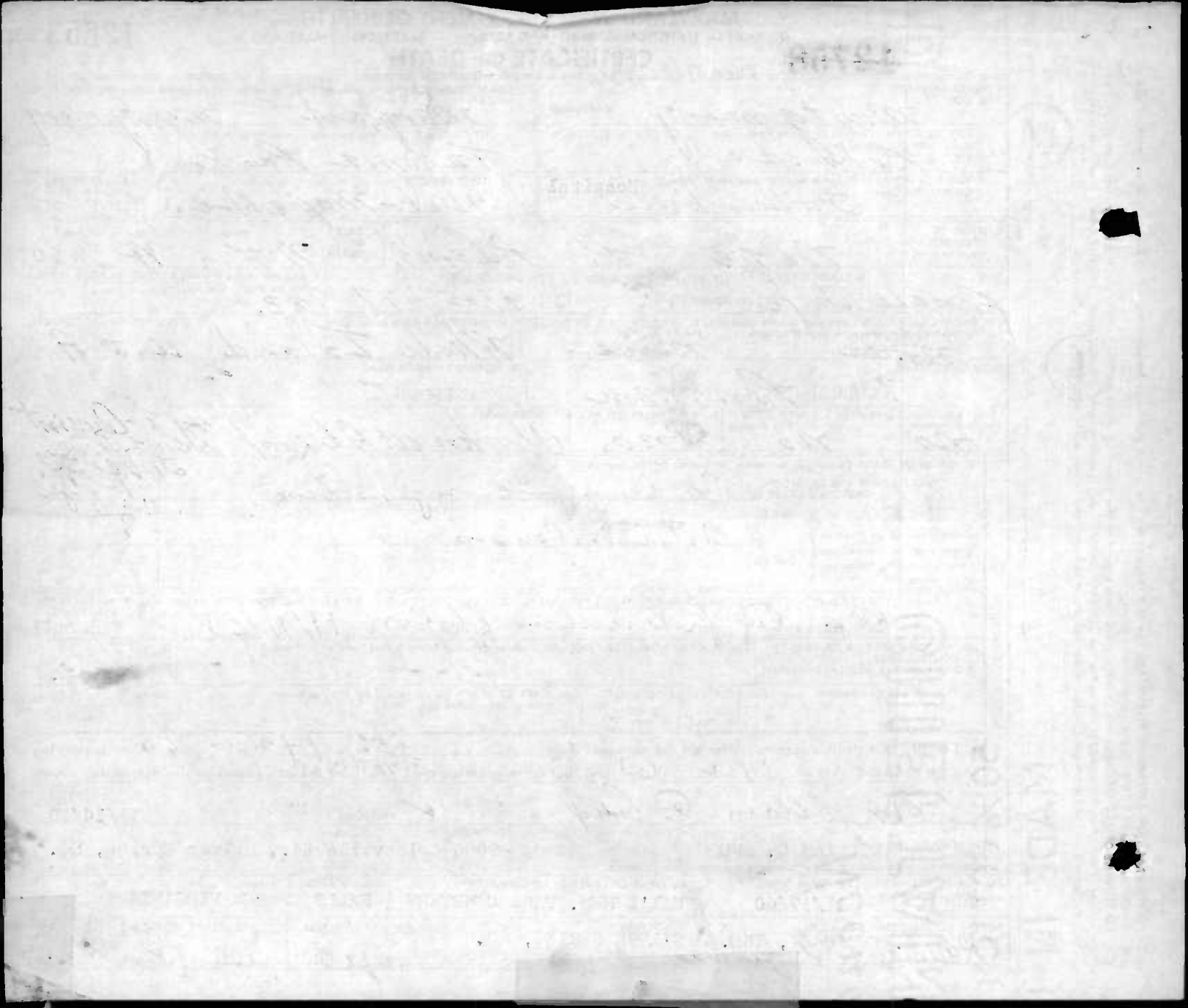
CERTIFICATE OF DEATH

12653

Item 7 Film 215 11-28-60 et

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> Hospital		d. STREET ADDRESS <u>7124-Maple Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>P.</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/177</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Linkham</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Clinton W. Adams</u> Address <u>4/8-Quaint</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>?</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operated for carcinoma of colon 11/11/60</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>11</u> Day <u>12</u> Year <u>1960</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>14 Nov.</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>60</u> , and that death occurred on <u>3:46 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. Aud</u> M.D.		22b. DATE SIGNED <u>11/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VIRGINIA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12759
12654
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clayton J. Bacher, SR.</i>		4. DATE OF DEATH <i>Nov. 15 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/30/08</i>
9. AGE (In years last birthday) <i>52 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gen. Lt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Special Police</i>	
11. BIRTHPLACE (State or foreign country) <i>Burlington, Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FREDERICK A. BACHER</i>		14. MOTHER'S MAIDEN NAME <i>HILDA B. FROHARDT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> (If yes, give war or dates of service) <i>WW #2</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Dorothy M. Bacher, 12,906 Ga. Ave. Silver Spring, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Cardiac shock</i> DUE TO <i>199.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Left pleural effusion</i> DUE TO (c) <i>Probable Carcinoma of the lung</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Calcific aortic stenosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>4 weeks</i> <i>6 months</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 15 1960</i> to <i>Nov 15 1960</i> , that (I) (we) lost saw the deceased alive on <i>Nov 15 1960</i> , and that death occurred at <i>11:45</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Blaine H. Fig</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Blaine H. Fig</i>		22d. ADDRESS <i>7041 Colson Rd Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11/18/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>DATE NOV 22 '60</i>	
ADDRESS <i>SILVER SPRING, MD.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

1891

1878

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

Form for recording vital statistics, including fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Birth. The form is divided into sections for the deceased and the informant.

DECEASED		INFORMANT	
NAME	SEX	NAME	SEX
AGE	DATE OF BIRTH	AGE	DATE OF BIRTH
DATE OF DEATH	CAUSE OF DEATH	DATE OF DEATH	CAUSE OF DEATH
PLACE OF BIRTH	PLACE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH

12679

CERTIFICATE OF DEATH

Reg. Dist. No. 12655

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,004 Flack Street		d. STREET ADDRESS 13,004 Flack Street	
3. NAME OF DECEASED (Type or print) DEANNE MARY JEANNE BAUSCH		4. DATE OF DEATH Month NOV Day 9 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/47
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE M. BAUSCH		14. MOTHER'S MAIDEN NAME MARY WILKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Eugene M. Bausch, 13,004 Flack Street Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory depression</u> DUE TO <u>Brain damage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydrocephalus</u> (c) <u>Extremely small vitelline cavity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>13 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Nov</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D.		ADDRESS (Street, city or town, state) <u>4323 Harvard St</u> DATE SIGNED <u>11/10/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY, MD</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/11/60	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1963

PLACE OF DEATH HOME		DECEASED NAME	
SEX FEMALE		DATE OF BIRTH 10-10-1900	
RACE WHITE		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION HOUSEWIFE		MARITAL STATUS MARRIED	
DATE OF DEATH 10-15-1963		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF INTERMENT GREENWICH CEMETERY		NAME OF FUNERAL HOME GREENWICH FUNERAL HOME	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1963.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12760
CERTIFICATE OF DEATH
12656

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 104 Days		d. STREET ADDRESS 401 C Street N.W. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peggy Middle Ann Last Beavers		4. DATE OF DEATH Month November Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1940
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Not employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus Beavers		14. MOTHER'S MAIDEN NAME Lona Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 229-52-3002	
17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and Septicemia 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Acute lymphocytic leukemia DUE TO (c) 15 months		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 22 1960 to November 3 1960 , that (I) (we) last saw the deceased alive on November 3 1960 and that death occurred at 5:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Vincent H Bono Jr. M.D.		22b. DATE SIGNED 11/ 4/ 60	
22c. PHYSICIAN'S NAME (Type) Vincent H Bono, Jr., M.D.		22d. ADDRESS The Clinical Center National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Nov 4 1960	
23c. NAME OF CEMETERY OR CREMATORY Richland Va		23d. LOCATION (City, town, or county) (State) Richland Va	
24. FUNERAL DIRECTOR'S SIGNATURE Walter Deal Funeral 4812 Ga Ave NW		25a. REC'D BY REGISTRAR NOV 14 '60	
ADDRESS 4812 Ga Ave NW		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

12755

12755

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

INDUSTRY

TRADE

PROFESSION

ART

SCIENCE

LITERATURE

TECHNICAL

MANUAL

AGRICULTURE

FISHERY

MINING

CONSTRUCTION

TRANSPORTATION

COMMERCE

INDUSTRY

TRADE

PROFESSION

ART

SCIENCE

LITERATURE

TECHNICAL

MANUAL

AGRICULTURE

FISHERY

MINING

CONSTRUCTION

TRANSPORTATION

COMMERCE

INDUSTRY

TRADE

PROFESSION

ART

SCIENCE

LITERATURE

TECHNICAL

MANUAL

AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12742

CERTIFICATE OF DEATH

Reg. Dist. No.

12657

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maryland Rest Home</u>		d. STREET ADDRESS <u>3116 Rolling Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A</u> Last <u>Beeler</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1878</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Hickey</u>		14. MOTHER'S MAIDEN NAME <u>Anne Ryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/3</u> , 19 <u>60</u> to <u>10/3</u> , 19 <u>60</u> that I last saw the deceased alive on <u>10/29</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Hamascus, Md.</u> DATE SIGNED <u>11/1/60</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Home Care</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Rest Home</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 4 '60</u>	
ADDRESS <u>5103 Wisconsin Ave. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Thomas</u>	

CERTIFICATE OF DEATH

1874

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain details about a death, including names and dates.]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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12761

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12658

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mon tgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RDI, Gaithersburg</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ANNIE Elizabeth</i> First Middle Last		4. DATE OF DEATH <i>Nov. 1, 1960</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 21, 1877</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Daughter: Minnie Tyler, RDI</i>		Address <i>Gaithersburg</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Decompensation</i> DUE TO (c) <i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>4 yrs.</i> <i>4 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c) <i>Arteriosclerosis cerebro-vascular occlusion</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1955</i> , 19 to <i>11-1</i> , 1960, that (I) (we) last saw the deceased alive on <i>10-31</i> , 1960, and that death occurred at <i>2A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Clive E. Jackson</i>		22b. DATE SIGNED <i>11-1-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Clive E. Jackson</i>		22d. ADDRESS <i>202 Martin Ln., Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/4/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Brooke Grove.,</i>		23d. LOCATION (City, town, or county) (State) <i>Laytonsville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>	
25a. REC'D BY REGISTRAR <i>NOV 3 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	



(Faint handwritten signature)

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see Martin's, Oct. 11, 11.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12762

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12659

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>33 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 BETHESDA</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>1 4008 Bradley Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>W</u> Middle <u>BELL</u> Last		4. DATE OF DEATH <u>11/2/60</u> Month <u>19</u> Day <u>19</u> Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/14/85</u> 9. AGE (In years lost birthday) <u>74</u> yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Nathan Bell</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Daughter Miss Emma Bell Same as Item 2</u>	
17. INFORMANT <u>Daughter Miss Emma Bell</u> Address <u>Same as Item 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>myocardial infarction</u> DUE TO <u>12 hrs.</u> (c) <u>arteriosclerotic heart disease</u> DUE TO <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1957</u> to <u>Nov 2 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 2 1960</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Malfred R. Ehrmentraut</u> M.D.		22b. DATE SIGNED <u>Nov 2 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Malfred R. Ehrmentraut MD</u>		22d. ADDRESS <u>4890 Bethany Lane, Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXXXX</u>		23b. DATE THEREOF <u>11/5/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>300-4th St. N.E.</u>		25a. REC'D BY REGISTRAR <u>NOV 4 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12660

12763

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. STREET ADDRESS 18200 Rayburn Avenue, Wheaton				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			
3. NAME OF DECEASED (Type or print) First Martha Middle Anne Last Belyea				4. DATE OF DEATH Month Nov. Day 11 Year 1960			
5. SEX F		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1867	
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months 11 Days 16 Hours 00 Min.		IF UNDER 24 HRS. Months 11 Days 16 Hours 00 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house-wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME Jessie Crowse				14. MOTHER'S MAIDEN NAME Eunice M. Sprague			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Florence Tisdale-daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Generalized 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerotic Cardiovascular disease, Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 10+ yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 1960 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-21-1960 to 11-11-1960 that (I) (we) last saw the deceased alive on 11-10-1960 , and that death occurred on 11-11-1960 at 3:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE James M. Whitlock MD				22b. DATE SIGNED 11-11-60		22c. PHYSICIAN'S NAME (Type) James M. Whitlock MD	
22d. ADDRESS 7717 Canell Ave Takoma Park							
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 11/15/60		23c. NAME OF CEMETERY OR CREMATORY Needham Cemetery		23d. LOCATION (City, town, or county) (State) Boston, Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Howard							

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1970

CERTIFICATE OF DEATH

1. Name of deceased: *Robertson, Robert*
2. Sex: *Male*
3. Date of birth: *1925*
4. Date of death: *1970*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *Dr. J. H. Smith*
8. Signature of registrar: *John Doe*
9. Signature of informant: *John Doe*
10. Name of informant: *John Doe*
11. Address of informant: *123 Main St.*
12. City: *Springfield*
13. State: *Ill.*
14. County: *Clark*
15. Date of filing: *1970*
16. Registrar's name: *John Doe*
17. Registrar's address: *123 Main St.*
18. Registrar's city: *Springfield*
19. Registrar's state: *Ill.*
20. Registrar's county: *Clark*
21. Registrar's date of filing: *1970*

Robertson, Robert
Male
1925
1970
Home
Heart disease
Dr. J. H. Smith
John Doe
John Doe
John Doe
123 Main St.
Springfield
Ill.
Clark
1970
John Doe
123 Main St.
Springfield
Ill.
Clark
1970

may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 12 Film G276 12-9-60 et

12743

CERTIFICATE OF DEATH

Reg. Dist. No.

12661

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington,</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall N. H.</u>				d. STREET ADDRESS <u>2900 Terrace Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ella Blanche</u> First Middle Last <u>Bishop</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired telegrapher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hillsbor, New Brunswick, Canada</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>E. Chipman Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Susan Eliza</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>010-03-6406A</u>			
17. INFORMANT <u>Col. Herbert B. Nichols</u>				Address <u>2900 Terrace Dr. Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis generalized</u> DUE TO (c) <u>Hypostatic pneumonitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 17, 1960</u> to <u>Nov. 20, 1960</u> , that I last saw the deceased alive on <u>Nov. 17, 1960</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred S. Norton</u>				ADDRESS (Street, city or town, state) <u>4711 Highland Ave Bethesda Md 11/20/60</u>			
PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>				DATE SIGNED <u>11/20/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>11-22-60</u>		<u>St. James Church</u>		<u>Cambridge, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, Inc.</u>				ADDRESS <u>Arlington, Virginia</u>			
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12702

Item 6 Film 6275 11-22-60 et

12662

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>16 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hosp.</u>		d. STREET ADDRESS <u>14004 Isabella STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>(Wm)</u> Last <u>Blaser</u>		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-'88</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>England</u>
12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		13. FATHER'S NAME <u>Ralph Goldseller</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia un Moritz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Chronic congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> 19 <u>60</u> to <u>November 14</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov. 14</u> 19 <u>60</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Adam W. Davis</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ADAM W. DAVIS</u>		22d. ADDRESS <u>927 Pershing Rd. Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/17/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>King David Cem. Ph Falls Church, Va</u>		23d. LOCATION (City, town, or County) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Salzburg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4217-957 N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		DATE <u>NOV 17 '60</u>	

1948

CHEMICAL OF DEPT

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NOV 1948

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764

CERTIFICATE OF DEATH

12663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmore Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle BONWIT Last BONWIT				4. DATE OF DEATH Month November Day 2 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1882	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amnon Behrend				14. MOTHER'S MAIDEN NAME Sarah Behrend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT Address Mrs. Edgar Stromberg-3173 Porter St., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis + hemorrhage DUE TO (b) cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3 mos 1-5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Jan 1950 , to Nov 2, 1960 , that I last saw the deceased alive on 10/26 , 19 60 , and that death occurred at 10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul R Wilner				ADDRESS (Street, city or town, state) 2500 Calvert St N.W Wash D.C.			
DATE SIGNED Nov 9 '60							
PHYSICIAN'S NAME (Type) PAUL R. WILNER, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-6-60	22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., NW				24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

12784

FOR
MAY 1910

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12765

12664

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Chevy Chase</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>A.</i> Last <i>Brand</i>				4. DATE OF DEATH Month <i>11</i> Day <i>10</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-79</i>		9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alexander Brand</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Glenn Stewart</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lillian Brand - Sister - 2d</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) DUE TO <i>Acute congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO <i>Myocardial insufficiency</i> (1+yr.) (c) DUE TO <i>Coronary arteriosclerosis</i> 5 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic pulmonary fibrosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i> <i>1+ yr.</i> <i>5 yrs.</i>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5 Nov 1960</i> to <i>10 Nov 60</i> , that (I) (we) last saw the deceased alive on <i>10 Nov 60</i> and that death occurred on <i>11 Nov 60</i> at <i>5:55 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>H. H. Richwine</i>				22b. DATE SIGNED <i>11 Nov 60</i>			
22c. PHYSICIAN'S NAME (Type) <i>H. H. RICHWINE</i>				22d. ADDRESS <i>5522 WESTERN AVE. BETHESDA, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenhill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Luray, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>NOV 14 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frame</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12766
CERTIFICATE OF DEATH
12665

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 3225 S. Utah Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Diana Middle Lyman Last BRANDT				4. DATE OF DEATH Month November Day 22 Year 1960									
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-60		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Hours 2 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George E. BRANDT, JR.						14. MOTHER'S MAIDEN NAME Aileen ALLEN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address (F) Geo. E. Brandt, Jr., same as #2 above									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMATURITY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 20 1960 to Nov. 22 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 22 1960 , and that death occurred at 3:55AM , from the causes and on the date stated above.													
22a. SIGNATURE Robert V. Rack				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 11-22-60					
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REGISTRY REGISTRAR DATE NOV 28 80		25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

2051353XVD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR AIS (4)
ISM 9/59

12767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12666

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.U.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wellington</u> Middle <u>Cicero</u> Last <u>Brannon</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>landscape artist-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knights & Postwick Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Albert Brannon</u>		14. MOTHER'S MAIDEN NAME <u>Nattie M. Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT (son-in-law) <u>J. U. Deaton</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>11-21</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-20</u> , 19 <u>60</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>11-21-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602 Georgia Ave Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska</u>		25a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

BP

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12768

CERTIFICATE OF DEATH

Reg. Dist. No.

12667

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise M. BRENNAN		4. DATE OF DEATH Month Day Year Nov. 28 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18 1898
9. AGE (In years lost birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME LINDERMUTH	
14. MOTHER'S MAIDEN NAME ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address John J. Shandis (Grandson) Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Constrictive Heart Failure Artherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/27 , 19 60 , to 11/28 , 19 60 , that I last saw the deceased alive on 11/28 , 19 60 , and that death occurred at 6:45 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Timothy J. Tehan		ADDRESS (Street, city or town, state) 8218 Wisconsin Ave. Bethesda Md.	
PHYSICIAN'S NAME (Type) TIMOTHY J. TEHAN		DATE SIGNED 11/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/60	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Pattsville, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Md.		24a. REC'D BY REGISTRAR DEC 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

12782

CERTIFICATE OF DEATH

STATE OF NEW YORK

12782

DECEASED

NEW YORK

12782

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12769
CERTIFICATE OF DEATH

12668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montgomery</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		47X-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>924 Upshur Street N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Riggs Bright</u>				4. DATE OF DEATH Month Day Year <u>Nov. 6 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/65</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanical engineer. Navy Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Bright</u>				14. MOTHER'S MAIDEN NAME <u>un known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>10511 Summit Ave Kensington, Md</u>		17. INFORMANT <u>Oscar P. Mast - 924 Upshur St N.E.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5 1960</u> to <u>Nov 6 1960</u> that (I) (we) last saw the deceased alive on <u>Nov 6 1960</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George Sharpe</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 6 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				22d. ADDRESS <u>10511 Summit Ave Kensington, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

12770

CERTIFICATE OF DEATH

Reg. Dist. No. 12669

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>J.</u> Last <u>Brogden</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-30-1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Brogden</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-09-5165</u>			
17. INFORMANT <u>Leticia (wife)</u>				Address <u>1344 D St NE Wash DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>Bronchopneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent Bronchogenic Carcinoma</u> DUE TO <u>Right Lung</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 19</u> , 19 <u>60</u> , to <u>Nov 12</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>Nov 12</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward A. Beeman</u>				ADDRESS (Street, city or town, state) <u>10620 Ga Ave Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u> </u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Newde</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1917

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12703

12670

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN lb <u>4 days</u>				d. STREET ADDRESS <u>7124 Maple Ave 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lenore</u> Middle <u>(N.M.N.)</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-85</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Houey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dodge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>U.S. Hosp. Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Congestive failure</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diaphragmatic hernia, Fracture of spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (the hospital) attended the deceased from <u>Oct 17</u> 19 <u>60</u> , to <u>Nov. 2</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 1</u> 19 <u>60</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/2/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>918 Univ. Blvd. E., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 5, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Danby Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Danby Michigan</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. Washington 12, D.C.</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 4 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Chana</u>	

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12703

CERTIFICATE OF DEATH

12703

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12771

CERTIFICATE OF DEATH

12671

Items 2, 8, 11-28-60 et Items 8, 6276, 12/2/60, et

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Missouri Md. b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Springfield 3001-4	
d. STREET ADDRESS 1326 Ensor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willie Middle Lee Last Brown		4. DATE OF DEATH Month November Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1929
9. AGE (In years last birthday) 26 1/2 yrs.		IF UNDER 1 YEAR Months 26 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Brown		14. MOTHER'S MAIDEN NAME Neomi (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxic Brain Damage DUE TO Cardiac Arrest with Asystole - 8 minutes 11-10-60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Acute Intermittent Porphyria (c) 20 months		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 29, 1960 to November 14, 1960 that (I) (we) last saw the deceased alive on November 14, 1960 and that death occurred 4:53 P.M. from the causes and on the date stated above.		22a. SIGNATURE Manuel S. Hellman, M.D.	
22b. DATE 11/15-60		22c. PHYSICIAN'S NAME (Type) Manuel S. Hellman, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/60	
23c. NAME OF CEMETERY OR CREMATORY Carvel Memorial Park		23d. LOCATION (City, town, or county) (State) Laurel, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. N.W.		25a. REC'D BY REGISTRAR DATE NOV 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

and Chas. B. Lewis, 1639 N. Broadway, Balto., Md.

12334

INVESTIGATION OF DEATH

Autopsy

Findings

The Cause of Death

History of Present Illness

History of Past Illness

32

Physical Examination

Frank Brown

Frank Brown

Medical History

Family History

Physical Examination

Medical History

On October 22, 1940

November 1940

Investigation of Death

Frank Brown

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12772
CERTIFICATE OF DEATH

12672

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 1 6648 Hillandale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Belle T. Bump				4. DATE OF DEATH Month 11 Day 22 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/1893			
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
13. FATHER'S NAME William Edward Tupper				14. MOTHER'S MAIDEN NAME Martha Howe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Merle J. Bump, husband Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.								INTERVAL BETWEEN ONSET AND DEATH Approx. 2 yrs 2	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from October 19, 1960 to Nov. 22, 1960 , that (I) (we) last saw the deceased alive on Nov. 22, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE George A. Pray, Jr.				22b. DATE 11/22/60		22c. PHYSICIAN'S NAME (Type) George A. Pray, Jr. M.D.			
22d. ADDRESS 4750 Chevy Chase 15, Md.				22e. ADDRESS 4750 Chevy Chase 15, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit				23b. DATE THEREOF 11/23/60		23c. NAME OF CEMETERY OR CREMATORY Ulysses Cemetery			
23d. LOCATION (City, town, or county) Ulysses, Penna.				23e. LOCATION (City, town, or county) Ulysses, Penna.		23f. LOCATION (City, town, or county) Ulysses, Penna.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24b. ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 28 1960			
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass				25c. REGISTRAR'S SIGNATURE Arthur S. Kneass					

9551

100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12753

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12673

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,815 Caldwell Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PEARL Middle ELIZABETH Last BURKE				4. DATE OF DEATH Month NOV. Day 16 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/85		9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Clerk - retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN A. SEILER				14. MOTHER'S MAIDEN NAME MAGDELINE SUMMERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Raymond J. Greenwich, 3324 Clay St. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enter abdominal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suspected abdominal malignancy (not confirmed) Deceased refused hospitalization (c) unknown INTERVAL BETWEEN ONSET AND DEATH 6 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Nov 1960 , to 16 Nov 1960 , that (I) (we) last saw the deceased alive on 15 Nov 1960 , and that death occurred at 10 AM , from the causes and on the date stated above.							
22a. SIGNATURE Herbert Martyn Jr				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 Nov 60	
22c. PHYSICIAN'S NAME (Type) HERBERT MARTYN JR				22d. ADDRESS 5029 Bethesda Ave Beth. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/19/60		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jaska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE NOV 22 '60	
				25b. REGISTRAR'S SIGNATURE Charles E. Hanna			

WARNER E. PUMPHREY, INC.

SILVER SPRING, MD.

DATE NOV 22 '60

Charles E. Hanna

655

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12674

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 2 hrs. 45 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles First Antonia Middle Burriss Last 4. DATE OF DEATH November Month 9 Day 19 Year 60			5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4/1/60 9. AGE (In years last birthday) yrs. 7 Months 8 Days 8 Hours 8 Min. 8 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) I 10b. KIND OF BUSINESS OR INDUSTRY 1 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Margaret Burriss 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1 16. SOCIAL SECURITY NO. 1 17. INFORMANT Hospital Records, Address Olney, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 527.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Atelectasis & edema DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died while undergoing right inguinal hernia repair under ether anesthesia. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/9/60 ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type) Frank J. Broschart, M.D. Address (Street, city, town, or county)			22a. BURIAL, CREMATION, REMOVAL (Specify) B urial 22b. DATE THEREOF 11/11/60 22c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery 22d. LOCATION (City, town, or country) (State) Sandy Springs Md.		
23. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville Md. 24a. REC'D BY REGISTRAR NOV 15 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12774
CERTIFICATE OF DEATH

12675

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL BUTTRY First Middle Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10/9/79 9. AGE (In years last birthday) 81 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 100. 11. BIRTHPLACE (State or foreign country) TENN. 12. CITIZEN OF WHAT COUNTRY? U. S. A.		4. DATE OF DEATH Month Day Year NOVEMBER 7 19 60 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME Lum C. Buttry		14. MOTHER'S MAIDEN NAME GETTY LOUISE BUTTRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1956 to November 7, 1960 , that (I) (we) last saw the deceased alive on November 7, 1960 , and that death occurred at 11:06 A.M. from the causes and on the date stated above.			
22a. SIGNATURE G. F. MEADORS, M. D. 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 11/7/60 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10-60	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		25a. REC'D BY REGISTRAR NOV 9 '60 25b. REGISTRAR'S SIGNATURE Carlan L. Hines	

CERTIFICATE OF DEATH

1277

MONTGOMERY

MARYLAND

MONTGOMERY

CATHESBURG

5 DAYS

DECEASED

NO 2 X

MONTGOMERY GENERAL HOSPITAL

NOVEMBER 7 W 50

DECEASED

DECEASED

10/12/50

WHITE

MALE

U. S. A.

DECEASED

DECEASED

DECEASED

HOSPITAL RECORDS

DECEASED

DECEASED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12775

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12676

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, MD				c. LENGTH OF STAY IN 1b 16 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON NURSING HOME				d. STREET ADDRESS 4314 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH F. CAMPBELL				4. DATE OF DEATH Nov 16, 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 18 1890	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Wash, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, U.S.P.O. Dept.				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Campbell				14. MOTHER'S MAIDEN NAME Catherine Clancy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. M.J. Casey Address niece	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332x DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1960 to Nov. 16, 1960 , that (I) (we) last saw the deceased alive on Nov. 15, 1960 , and that death occurred at 3:20 PM from the causes and on the date stated above.							
22a. SIGNATURE F. F. Thibadeau				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F. F. Thibadeau				22d. ADDRESS 10111 Colesville Rd Silver Spring Md.			
23a. BURIAL, CREMATION, or other disposition of body burial		23b. DATE THEREOF 11/18/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co				ADDRESS 2901-14 St. N.W.		25a. REC'D BY REGISTRAR DATE NOV 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

12372

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 15, 1900*
5. Date of death: *Jan 20, 1945*
6. Place of death: *New York City*
7. Cause of death: *Heart disease*
8. Signature of physician: *[Signature]*
9. Signature of registrar: *[Signature]*
10. Date of registration: *Jan 25, 1945*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12776 CERTIFICATE OF DEATH 12677

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS No. 1 Port Green, S.W.			
3. NAME OF DECEASED (Type or print) First Kelly Middle Ann Last CARPENTER				4. DATE OF DEATH Month November Day 29 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-60	
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3		11. IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min. 3			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Earl CARPENTER				14. MOTHER'S MAIDEN NAME Ann Marie MAHAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - -				16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) James E. Carpenter, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 754.5 IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE DUE TO (b) 70 HOURS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 70 HOURS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 70 HOURS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 26, 1960, 8:38PM to Nov. 29, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 29, 1960 , and that death occurred at 11-30-60 , from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Rack				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-30-60	
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-2-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Morris				ADDRESS Arlington, Va.		25a. RECEIVED BY REGISTRAR DEC 1 1960	
Arlington Funeral Home, 3901 N. Fairfax Drive,				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

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OFFICE OF THE DISTRICT ATTORNEY

Division of Columbia

Montgomery

Bedford (Amel)

2 days

Washington

U. S. Naval Hospital

No. 1 Post Office, S.W.

Kelly

Ann

C. R. R. R.

November

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Female

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11-28-00

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U.S.A.

Maryland

James Earl Carpenter

Ann Marie Kinn

No (7) James E. Carpenter, same as above

Nov. 29 1900

11-29-00

Robert T. Mack, Jr., U.S. Naval Hospital, Bethesda, Md.

Arlington National

Arlington, Va.

Virginia

Arlington National Home, 3001 N. Potomac Drive

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12678

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
MONTGOMERY		MARYLAND	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
CHARLES HAIG CARTER		NOVEMBER 22 1960	
5. SEX		6. COLOR OR RACE	
MALE		WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		6/25/1888	
9. AGE (In years last birthday)		IF UNDER 1 YEAR	
72 yrs.		Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
MECHANIC			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MASSACHUSETTS		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN I. CAIG		DELIA A. CUMMINGS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
		218-14-5928	
17. INFORMANT		Address	
HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 1/2 hrs	
451X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Rupture of Abdominal aortic Aneurysm			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
F. J. BROSCART, M. D.		DATE SIGNED 11/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		11-26-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Rockville Union		Rockville Md.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
E. G. Garton		DATE NOV 29 '60	
24b. REGISTRAR'S SIGNATURE		25. REGISTRAR'S SIGNATURE	
Arthur S. Kraus		Arthur S. Kraus	

TOP FILE
DEATH NO.

(N)

10777

MONTGOMERY

CLINT. NO.

0 0 A

ROCKVILLE

320 EAST MONTGOMERY AVE.

MONTGOMERY GENERAL HOSPITAL

CHARLES

HAIR

CASTER

NOV-40-12

WIFE

WHITE

6-25-1930

72

MECHANIC

MASSACHUSETTS

U. S. A.

JOHN I. CAIS

DELA. A. CUNNING

HOSPITAL RECORDS, CLINT. NO.

67-12-1930

(1)

11-23-30

F. J. BROCKHART, M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
12778
MONTGOMERY
OLNEY
MONTGOMERY GENERAL HOSPITAL
11
R-3
12679
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 34 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELLEN Last CAU FIELD		4. DATE OF DEATH Month NOVEMBER Day 26 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 3, 1865
9. AGE (In years lost birthday) yrs. 95		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	
11. BIRTHPLACE (State or foreign country) Clopper Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME WILLIAM R. HUTTON		14. MOTHER'S MAIDEN NAME MARY AUGUSTA CLOPPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS, OLNEY, MARYLAND	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 422.2 DUE TO Chronic Myocarditis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia. (c) Uremia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 4:35		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25 to 11/26 , 19 60 that (I) (we) last saw the deceased alive on 11/25 , 19 60 , and that death occurred at 4:35 M, from the causes and on the date stated above.			
22a. SIGNATURE L. I. Leal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60	
23c. NAME OF CEMETERY OR CREMATORY St. Rose		23d. LOCATION (City, town, or county) (State) Clopper. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		25a. REC'D BY REGISTRAR DATE NOV 29 '60	
ADDRESS Gaithersburg. Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Heart Failure
Chronic Hypertension
— Chronic

1925 11/50

1925 11/50
Lung Cancer

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12680

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>MONTG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Silver Spring</u>			
c. LENGTH OF STAY IN TB <u>2 yrs</u>				d. STREET ADDRESS <u>19914 Capitol View Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9914 Capitol View Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Vernie Gertrude Chapman</u>				4. DATE OF DEATH <u>11-13-1960</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>4-10-84</u>			
9. AGE (In years last birthday) <u>76</u> yrs.				10. IF UNDER 1 YEAR Months Days			
11. IF UNDER 24 HRS. Hours Min.				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Hayseel</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Lyon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Raymond Chapman (son)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Acute congestive heart failure</u> DUE TO (b) <u>Cerebral vascular accident</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days 2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-13-60</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>				22b. DATE THEREOF <u>11/16/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Beech Grove Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Pomeroy, Meigs County, Ohio</u>			
23. FUNERAL DIRECTOR <u>WILLIAM E. PUMPHREY, INC.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>			
ADDRESS <u>SILVER SPRING, MD.</u>				24b. REGISTRAR'S SIGNATURE			
Signature <u>Raymond A. Ziska</u>				DATE <u>NOV 17 '60</u>			

MEDICAL CERTIFICATION

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12081

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keensington</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Keensington</u>			
c. LENGTH OF STAY IN <u>12</u>				d. STREET ADDRESS <u>15001 Aurora St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5001 Aurora St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nicholas Joseph Cibula</u>				4. DATE OF DEATH Month Day Year <u>nov 9 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-24-60</u>	
9. AGE (in years last birthday) yrs. <u>17</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State of foreign country) <u>Doctor's Hospital, Wash, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Joseph Cibula</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Douglas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Joe, Cibula - father -</u>				Address <u>Stuen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11-9-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	
				22d. LOCATION (City, town, or country) (State) <u>Silver Spring Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59

90000000X00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12704

12682

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
4. DATE OF DEATH First Middle Last <u>Addie</u> <u>Viola</u> <u>Clapp</u>				4. DATE OF DEATH Month Day Year <u>11</u> - <u>29</u> - <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-13-69</u>			
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Wm. Henry Dean</u>				14. MOTHER'S MAIDEN NAME <u>Ella Hollister</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Hospital Records</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (the hospital) attended the deceased from <u>11/19</u> 19 <u>60</u> to <u>11/29</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> 19 <u>60</u> , and that death occurred at <u>6:15</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Eino Magi</u>				22b. DATE SIGNED <u>11/29/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>918 Univ. Bldg E, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>DEC. 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>			
23d. LOCATION (City, town, or county) <u>PRINCE GEO. COUNTY</u>				(State) <u>MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>DEC 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			
ADDRESS <u>254 Carroll ST. NW Wash, DC</u>									

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12779

CERTIFICATE OF DEATH

Reg. Dist. No.

12683

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, R.F.D		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, X d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Joseph Last Clements		4. DATE OF DEATH Month November Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 6-1882
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry L. Clements		14. MOTHER'S MAIDEN NAME Nellie M. Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-20-3902	
INFORMANT Mrs Regina Kibler, Gaithersburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from Jan , 1955, to Nov. 30 , 1960, that I last saw the deceased alive on Nov 29 , 1960, and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Vernon E. Martens M.D. Sermantown, Md. Dec 1-60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Vernon E. Martens Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 3-1960	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillman		ADDRESS Barnesville, Md	
24a. REC'D BY REGISTRAR DATE DEC 6 '60		24b. REGISTRAR'S SIGNATURE Robert E. Frazer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12739

State of Maryland
County of Prince George's
I, the undersigned, Clerk of the said County, do hereby certify that
the within and foregoing is a true and correct copy of the
original of the same as the same appears from the records of the
said County.
Witness my hand and the seal of the said County at the City of
Annapolis, this 1st day of January, 1900.
Clerk of the County of Prince George's

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12780
12684
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase	
3. NAME OF DECEASED (Type or print) First William Middle Cole Last Cole		4. DATE OF DEATH Month November Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/77
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Cole		14. MOTHER'S MAIDEN NAME Mary Jane McCauley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 208-01-8779	
17. INFORMANT Miss Gretchen Cole (daughter)		Address See Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 mo DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-7-60 to 11/1/60 that (I) (we) lost saw the deceased alive on 10/31/60 and that death occurred at 7A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul D. Cantor		22b. DATE SIGNED 11/1/60	
22c. PHYSICIAN'S NAME (Type) Paul D. Cantor		22d. ADDRESS 4709 Montgomery Lane, Bethesda Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/1/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Pina	

1308

CERTIFICATE OF DEATH

13780

200-01-8750
C. V. F. Cerebral vascular accident

2700 Montgomery Lane, Bethesda 10

Robert A. Montgomery, 10/1/50, 50 years old, Maryland

Robert A. Montgomery, 10/1/50, 50 years old, Maryland

12705

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>45-02 Ingham Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Elmer</u> Last <u>Collingwood</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-04</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>The Osso. Press</u>		11. BIRTHPLACE (State or foreign country) <u>Washington state</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Orlando</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth XXXXXXXX, LESLIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W. 2 366-10-2197</u>		INFORMANT <u>(wife) Mrs Ida Collingwood</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA (TERMINAL)</u> <u>AND ATelectasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRONCHOGENIC CARCINOMA WITH</u> (c) <u>CARCINOMATOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>(PROBABLE)</u> <u>9 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>OCT 12</u> , 19 <u>60</u> , to <u>NOV 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>NOV 24</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>				ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE. N.W. NOV 25 1960</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u>				LOCATION (City, town, or county) <u>WASHINGTON 12. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond E. Foster</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12702

CERTIFICATE OF DEATH



[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and location.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12686

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>5 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12000 Seney Rd</u>				d. STREET ADDRESS <u>112000 Seney Rd</u>			
3. NAME OF DECEASED (Type or print) <u>First (SARAH) Middle Rosaria Crivello</u>		4. DATE OF DEATH <u>Nov 18 1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>4-10-1871</u>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>89 yrs.</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Joseph Citrans</u>		14. MOTHER'S MAIDEN NAME <u>Rose Maisiglia</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Samuel Crivello (son) Silver Spring MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic Mellitus</u> DUE TO (c) <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-18-66</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or country) (State) <u>WASH D.C.</u>	
23. FUNERAL DIRECTOR <u>Wm. J. Hanlon</u>		ADDRESS <u>3831 Ga An Ave</u>		24a. REC'D BY REGISTRAR <u>NOV 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

1853

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Items 18&20 Film 278 1-7-63
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12706

CERTIFICATE OF DEATH

12687

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>W.O.A</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash Stn Hosp</u>			d. STREET ADDRESS <u>13129 Holdridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Kathy Jeanne Croker</u>			4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-60</u>		9. AGE (In years last birthday) yrs. <u>1</u> 1/2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dist of Columbia</u>
13. FATHER'S NAME <u>John V Croker</u>			14. MOTHER'S MAIDEN NAME <u>Kay Cancellier</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>MRS Kay Croker</u> Address <u>same as deceased</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>asphyxia</u> <u>924.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Blankets pulled against face when baby was alone in car.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Autopsy disclosed no other abnormalities contributing to death</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The baby was left alone in crib in car for 1/2 hr. about 3PM, 11/15/60. When mother returned baby was not breathing. She was rushed to a local MD and sent at once to Wash. Stn.</u>			
20c. TIME OF INJURY Hour <u>3</u> Minute <u>00</u> p.m. Month <u>11/15</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near Home</u>		20f. (City or town) (County) (State) <u>Silver Spring</u> <u>Montg</u> <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>60</u> to <u>11/15</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>60</u> and that death occurred at <u>4PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>George R. Spence</u>			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>GEORGE R. SPENCE</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>11/18/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>

CERTIFICATE OF DEATH

12-1-1918

100

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12782

CERTIFICATE OF DEATH

12688

1. PLACE OF DEATH a. COUNTY Montgomery b. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 11 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 6704 Floyd Ave.			
3. NAME OF DECEASED (Type or print) Infant Girl DANIEL				4. DATE OF DEATH Month November Day 17 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-60	
9. AGE (In years lost birthday) yrs.		10. AGE (In years lost birthday) yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -			
13. FATHER'S NAME Royal Thomas DANIEL, JR.				14. MOTHER'S MAIDEN NAME Lillian Martha ELLIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) R. T. Daniel, Jr., same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 5605 IMMEDIATE CAUSE (a) Congenital diaphragmatic hernia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 11 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that it (this hospital) attended the deceased from Nov. 16 19 60 to Nov. 17 19 60 , that it (we) last saw the deceased alive on Nov. 17 19 60 , and that death occurred at 9:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE C.W. Bramlett				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-17-60	
22c. PHYSICIAN'S NAME (Type) C.W. BRAMLETT, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-18-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE NOV 18 '60		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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18782

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

CERTIFICATE OF DEATH

Reg. Dist. No.

12689

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION <u>7702 Old Chester Rd.</u>		d. STREET ADDRESS <u>6402 16th St. N. W.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Wright Deal</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral Director</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Deal</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Roycroft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Anna Hall</u>		Address <u>7702 Old Chester Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>advanced coronary atherosclerosis</u> DUE TO (c) <u>severe generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1955</u> to <u>11/5, 1960</u> , that I last saw the deceased alive on <u>11/4, 1960</u> , and that death occurred at <u>5:27 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DB Washington</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D.</u>		<u>6234 Ga. Ave NW Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 8 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Deal</u>		ADDRESS <u>Home 4812 Ga. Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754

CERTIFICATE OF DEATH

Reg. Dist. No. 12690

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 4 1/2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) 12118 Galena Road			d. STREET ADDRESS 12118 Galena Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) VITO (NMN) De FILIPPIS			4. DATE OF DEATH Month November Day 2nd Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21st, 1870		9. AGE (In years lost birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason (retired)		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME John De Filippis			14. MOTHER'S MAIDEN NAME Mary Manicone		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT John DeFilippis, 304 S. Highland St. Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153. Pulmonary edema DUE TO (b) Carcinoma intestine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4/15/60 , 19____, to 11/2/60 , 19____, that I last saw the deceased alive on 11/1/60 , 19____, and that death occurred at 11:22 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Patrick C. Jameson		ADDRESS (Street, city or town, state) 12020 Georgia Ave. N.W.		DATE SIGNED 11/2/60	
PHYSICIAN'S NAME (Type) Patrick C. Jameson					
22b. DATE THEREOF 11/5/1960		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE NOV 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

BP 22

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12691											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>						c. LENGTH OF STAY IN lb <u>Dr. A.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg Gen Hosp</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Yenervia Estelle Demar</u>						4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-32</u>		9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Waitress</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>											
13. FATHER'S NAME <u>Hilary Demar</u>						14. MOTHER'S MAIDEN NAME <u>Bertha Stewart</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>						16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT <u>Colombus Demar - Youth. R-1 md</u>						Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO (b) <u>Bullet wound thru heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Shot in left chest with 25 cal revolver</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:15</u> p.m. <u>11-12</u> 19 <u>60</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Church yard</u>		20f. (City or town) (County) (State) <u>mt zein montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <u>11-13-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>11-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		22d. LOCATION (City, town, or country) (State) <u>Laytonville, Ind.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden - Rockville, Ind.</u>						ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>NOV 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7-11-11

12784

12784

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12784

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12784

CERTIFICATE OF DEATH

Reg. Dist. No.

12692

12785

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>L</u> Last <u>Derrick</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-70</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>John Derrick</u>	
14. MOTHER'S MAIDEN NAME <u>Christine Dominick</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>262-50-2033</u>		INFORMANT <u>John M. Derrick (son)</u> Address <u>4401 Brandwine St. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, advanced</u> DUE TO <u>10 yrs +</u> (c) <u>Arteriosclerosis, generalised</u> DUE TO <u>10 yrs +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction 1952</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>Nov 17</u> , 1960, that I last saw the deceased alive on <u>Nov 16</u> , 1960, and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>4740 Chevy Chase Dr. Washington, D. C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>11/17/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carling S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12786

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG275 11-29-60 et

Reg. Dist. No.

12693

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>4816-5th St., N. W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret E. Diggins</u>		4. DATE OF DEATH Month Day Year <u>11 16 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/82</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>11 16 1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Eli Luckett</u>		14. MOTHER'S MAIDEN NAME <u>Annie Agnes Holloran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>James Louis Diggins (son) 1312 Coral Sea,</u>	
17. INFORMANT <u>James Louis Diggins (son)</u>		Address <u>Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERIPHERAL VENOUS THROMBOSIS</u> DUE TO (c) <u>FRACTURE, RIGHT FEMUR</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>DAYS</u> <u>8 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>Slipped on floor of nursing home</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:15</u> p.m. <u>11-8-1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u> 20f. (City or town) (County) (State) <u>Rockville</u> <u>Montg</u> <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-17-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Collins</u>		ADDRESS <u>WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12787

CERTIFICATE OF DEATH

12694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Keyser	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS Rural Delivery # 3	
3. NAME OF DECEASED (Type or print) First Frank Middle (none) Last Domenic		4. DATE OF DEATH Month November 4, Day 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1914
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antonio Domenic		14. MOTHER'S MAIDEN NAME Pauline Scarpone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) World War II		16. SOCIAL SECURITY NO. 217-10-7124	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 411 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis & Insufficiency, post operative DUE TO (c) Rheumatic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 20 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Atelectasis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2 , 19 60 , to November 4 , 19 60 , that I last saw the deceased alive on November 4 , 19 60 , and that death occurred at 1:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William C. Awe M.D.		ADDRESS (Street, city or town, state) The Clinical Center, National DATE SIGNED 11/4/60	
PHYSICIAN'S NAME (Type) William C. Awe, M.D.		Institutes of Health, Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-7-60	22c. NAME OF CEMETERY OR CREMATORY St Thomas	22d. LOCATION (City, town, or county) (State) Keyser W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE J.H. Markwood & Sons ADDRESS Keyser, West Va.		24a. REC'D BY REGISTRAR NOV 7 1960 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

• *Ende*

15705



12708

CERTIFICATE OF DEATH

Reg. Dist. No. 12696

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>16833 Eastern Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>RAYMOND</u> Last <u>DOUGLAS</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8, 1885</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing agent - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edward M. Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Zilpha Childs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Wife - Mrs Marguerite Douglas</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, esophagus.</u> DUE TO <u>150x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec 27, 1957</u> to <u>Nov 23, 1960</u> , that I last saw the deceased alive on <u>Nov 23, 1960</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6216 NH Ave NE Washington DC</u> DATE SIGNED <u>11/23/60</u>							
ACTUAL SIGNATURE <u>William F Simpson, Jr.</u>				PHYSICIAN'S NAME (Type) <u>William F Simpson, Jr. Washington DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 26, 1960</u>		<u>GLENWOOD CEMETERY</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Kline</u> ADDRESS <u>WASH D.C. 254 CARROLL ST. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF CLERK		22. SIGNATURE OF JUDGE		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
12681					CERTIFICATE OF DEATH					12697				
										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X-5</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring 1 year</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALTEA Woodland</u>					d. STREET ADDRESS <u>2400 Wyoming Ave</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>IRMA E DRAYTON</u>					4. DATE OF DEATH <u>11 11 1960</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-19-1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>US</u>					13. FATHER'S NAME <u>THOMAS W. ELIASON</u>					14. MOTHER'S MAIDEN NAME <u>VIOLET BRIS COE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>No</u>					INFORMANT Address <u>Nursing Home Records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Bronchopneumonia (terminal)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO <u>10 yrs</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that I attended the deceased from <u>Nov 3</u> , 19 <u>60</u> , to <u>Nov 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-11</u> , 19 <u>60</u> , and that death occurred at <u>10/15 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Hill Carter</u> M.D.					ADDRESS (Street, city or town, state) <u>1835 Eye St NW</u>									
DATE SIGNED <u>Wash DC Nov, 60</u>														
17. NAME (Type) <u>HILL CARTER</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					22b. DATE THEREOF <u>11/14/60</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				
22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>														
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>					ADDRESS <u>Wash, D.C.</u>					24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>														

19081

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

19081

IN DECEASED, No.

Residence

Place of Birth

Occupation

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

Widow

Divorced

Never married

Married

Single

12682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 University Blvd. East		d. STREET ADDRESS 122 University Blvd. East	
3. NAME OF DECEASED (Type or print) First Mildred Middle Pearl Last Eby		4. DATE OF DEATH Month Nov. Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house-wife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Stull		14. MOTHER'S MAIDEN NAME Maryetta Armstrong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ascending colon 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastases to Liver & Lymph nodes original		INTERVAL BETWEEN ONSET AND DEATH 39 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27 , 19 58 , to Nov 5 , 19 60 , that I last saw the deceased alive on Nov 4 , 19 60 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Wardrop		ADDRESS (Street, city or town, state) 800 Pershing Drive Silver Spring Md.	
PHYSICIAN'S NAME (Type) W.B. WARDROP		DATE SIGNED Nov 5 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/8/60	22c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery	22d. LOCATION (City, town, or county) (State) Rural, Hampstead, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers, Jr. Westminster, Md.		24a. REC'D BY REGISTRAR NOV 9 60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BUREAU OF VITALS

15685

REGISTERED

OFFICE OF THE REGISTRAR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
12788
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12699

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARNESVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WINFIELD Middle SCOTT Last EDWARDS				4. DATE OF DEATH Month Nov. Day 8 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 6 Min.		11. IF UNDER 24 HRS. Months 8 Days 19 Hours 6 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor - County Rd. Maint. Maryland				10b. KIND OF BUSINESS OR INDUSTRY labor - County Rd. Maint. Maryland			
11. BIRTHPLACE (State or foreign country) labor - County Rd. Maint. Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mr. J.R. Lillard		17. INFORMANT Barnesville, Md (Friend)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CONJECTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) OLD C.V.A. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20 1960 to 11/7 1960 , that (I) (we) last saw the deceased alive on Nov 7 1960 , and that death occurred at 5:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Edward A. Beeman				22b. ADDRESS 10620 GEORGIA AVE. SILVER SPRING, MD.		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EDWARD BEEMAN				22d. ADDRESS 10620 GEORGIA AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 11/10/60		23c. NAME OF CEMETERY OR CREMATORY Monterey		23d. LOCATION (City, town or county) (State) Bethesda Md	
24. FUNERAL DIRECTOR'S SIGNATURE W.B. Hilton				25a. REC'D BY REGISTRAR DATE NOV 14 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

15788

CENTRAL AIR OF DEATH

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

12700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK, MD</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LIBA</u> Middle <u>ANN</u> Last <u>EHRLICH</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/60</u>	9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT A. EHRLICH</u>				14. MOTHER'S MAIDEN NAME <u>CAROL ANN ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ROBERT EHRLICH</u> Address <u>5814 30TH AVE. HYATTSVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776 X</u> IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>					
20c. TIME OF INJURY Month <u>NONE</u> Day <u>19</u> Hour <u>a.m.</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/7/60</u> to <u>11/12/60</u> , that I last saw the deceased alive on <u>11/12/60</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stanley L. Blumenthal</u> M.D. <u>10620 Georgia Silver Spring, Md.</u>				DATE SIGNED <u>12 APR 1961</u>			
PHYSICIAN'S NAME (Type) <u>STANLEY L. BLUMENTHAL</u>				ADDRESS <u>10620 GEORGIA AVE SILVER SPRING MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-12-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>TAKOMA PARK, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>				ADDRESS <u>Washington San. & Hosp.</u>		24a. REC'D BY REGISTRAR <u>NOV 16 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.
M

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND												2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus												c. LENGTH OF STAY IN 1b Burtonsville																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9113 Gue Rd.												d. STREET ADDRESS Blackburn Rd.																							
3. NAME OF DECEASED (Type or print) Charles Franklin Elliott												4. DATE OF DEATH Month Nov. Day 2 Year 1960																							
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4/8/97				9. AGE (In years last birthday) 63 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Norman L. Elliott Construction Co.												10b. KIND OF BUSINESS OR INDUSTRY Virginia												11. BIRTHPLACE (State or foreign country) U.S.A.											
13. FATHER'S NAME Thomas Marshall Elliott												14. MOTHER'S MAIDEN NAME Myrtle Frances Kidwell																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no												16. SOCIAL SECURITY NO. 215-26-3520												17. INFORMANT Norman L. Elliott, Burtonsville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH Sudden																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																							
EXAMINER'S NAME (Type) Frank J. Broschart												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
DATE SIGNED Nov. 2, 1960																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL												22b. DATE THEREOF 11/5/60				22c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery				22d. LOCATION (City, town, or country) (State) Montgomery County, Md.															
23. FUNERAL DIRECTOR WALTER E. BUMPHREY, INC. <i>Dymond A. Ziska</i>												ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR NOV 9 '60				24b. REGISTRAR'S SIGNATURE <i>C. L. S. Knaus</i>															

THE UNIT
RECEIVED
1944

12388

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VITAL STATISTICS

Form with multiple sections for data entry, including fields for name, date, and other vital statistics. The text is mirrored and difficult to read.

NAME: [Illegible]
DATE: [Illegible]
[Other illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12790

CERTIFICATE OF DEATH

12702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Cabin John</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>6431-79th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Noble B. Embrey</u>		4. DATE OF DEATH Month Day Year <u>Nov 30 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/15/82</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ref. U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MILTON FRANCIS EMBREY</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH CAYWOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-32-4521</u>	
17. INFORMANT <u>Silver Spring, Md.</u>		Niece <u>Mrs. P. Clark-2317 Blueridge Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Thrombosis Right Auricular Appendage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 1</u> , 19 <u>60</u> , to <u>NOV 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>NOV 30</u> , 19 <u>60</u> , and that death occurred at <u>7:35 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward A. Beeman</u>		ADDRESS (Street, city or town, state) <u>10620 GEORGIA AVE., 11/30/60</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		M.D. <u>SILVER SPRING, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

(I)

2

BP-1

18590

CERTIFICATE OF DEATH

STATE OF NEW YORK

18590

18590

18590

18590

18590

18590

18590

12710

CERTIFICATE OF DEATH

Reg. Dist. No.

12703

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. & Hosp.</u>				d. STREET ADDRESS <u>3111 Newton St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lore</u> Middle <u>Ann</u> Last <u>ENNIS</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 31, 1960</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James Patrick Ennis</u>				14. MOTHER'S MAIDEN NAME <u>Loretta Evelyn Carpenter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>762-0</u>		17. INFORMANT <u>Mathers Chart</u> Address <u>3111 Newton St. NE. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO <u>762-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>11</u> Day <u>4</u> Year <u>1960</u> Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u></u>							
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>60</u> , to <u>11/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>60</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Diamond</u>				DATE SIGNED <u>9/19/60</u>			
PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>				ADDRESS (Street, city or town, state) <u>Silver Spring Ave Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington</u> (State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>7901-14th St. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075181XV6

CERTIFICATE OF DEATH

Reg. Dist. No.

12791

12704

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>23 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>822 Underwood Hl N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Epstein</u> Last <u>Epstein</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Playland</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice Epstein</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lipsitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>212-18-5106</u>		INFORMANT <u>Lee Epstein (wife)</u>		Address <u>822 Underwood Hl N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>3 days</u> <u>3 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>55</u> , to <u>Nov 7</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>60</u> , and that death occurred at <u>9:36</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.				DATE SIGNED <u>10620 Georgetown 11/6</u>			
PHYSICIAN'S NAME (Type) <u>John J. Curry</u>				ADDRESS (Street, city or town, state) <u>Blue Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fair Meyer Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co</u> ADDRESS <u>3605-14 St NW Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
12744
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12705

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington n		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 39	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 10,411 Amherst Ave. 1	
3. NAME OF DECEASED (Type or print) John K. M. EWING		4. DATE OF DEATH Month November 1 Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/78
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Alien Property Custodian	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ewing		14. MOTHER'S MAIDEN NAME Virginia Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Kathleen E. Daly, S. Egremont, Mass.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Dilitation DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Small Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH App. 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 25 19 60 to Nov. 1 19 60 that (I) (we) last saw the deceased alive on Nov 1 19 60 , and that death occurred at 2:30 pm from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau, M.D.		22b. DATE SIGNED Nov 1, 1960	
22c. PHYSICIAN'S NAME (Print) Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord St., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond H. Ziska		25a. REC'D BY REGISTRAR DATE NOV 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

THE UNIVERSITY OF CHICAGO
 DIVISION OF THE PHYSICAL SCIENCES
 DEPARTMENT OF CHEMISTRY
 5708 SOUTH CAMPUS DRIVE
 CHICAGO, ILLINOIS 60637
 TEL: 773-936-5000
 FAX: 773-936-5000
 WWW: WWW.CHEM.UCHICAGO.EDU

CHICAGO, ILLINOIS 60637
 TEL: 773-936-5000
 FAX: 773-936-5000
 WWW: WWW.CHEM.UCHICAGO.EDU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

CERTIFICATE OF DEATH

12706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>29 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SHERI</u> Middle <u>LYNNE</u> Last <u>FARABEE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/13/60</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>29</u> Min. <u>30</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Ronald Warner Farabee</u>	
14. MOTHER'S MAIDEN NAME <u>Libby Sue Hughes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother</u> Address <u>Same as Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.00 Asthenia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Same date</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>birth</u> , 19 <u>—</u> , to <u>11/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/14/60</u> , 19 <u>—</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Winston E. Cochran 927 Peersing Dr. Silver Springs, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 17, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Orlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wallis</u> ADDRESS <u>254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

2075201XV4

CERTIFICATE OF DEATH

12341

Page 01 of 01

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES EARL RAY		Male		35	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
April 4, 1968		4:00 PM		Room 306, Federal Bureau of Investigation, Washington, D.C.	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
Shot by sniper fire		Homicide		Memphis, Tennessee	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. SIGNATURE OF PHYSICIAN	
None		None		[Signature]	
13. SIGNATURE OF CORONER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
[Signature]		[Signature]		None	

RECEIVED
APR 10 1968
FBI - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 275 11-22-60 et

12745

CERTIFICATE OF DEATH

Reg. Dist. No.

12707

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 Mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>9500 Byeford Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sant.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ritchey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>John Farrell 9500 Byeforde Rd.</u>	
17. INFORMANT <u>John Farrell 9500 Byeforde Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left hip (femur) Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Pt. apparently fell</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10</u> <u>11</u> <u>1960</u> p. m. <u>10</u> <u>11</u> <u>1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing home</u>		20f. (City or town) (County) (State) <u>Kensington Mont. Md.</u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Oct. 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>60</u> , and that death occurred at <u>12:55 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Lenord Gold</u>		ADDRESS (Street, city or town, state) <u>Eig Building Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. Lenord Gold M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 5 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Deal Funeral Home 4812 Ga. Ave.</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Coroner has been notified and the coroner released

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

CERTIFICATE OF DEATH

Reg. Dist. No.

12708

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>PA.</i> b. COUNTY <i>75X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>14 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNA L. Feldstein</i>		4. DATE OF DEATH Month Day Year <i>11 30 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-3-1983</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Lohren</i>		14. MOTHER'S MAIDEN NAME <i>Ernestine Weiden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Babette A. Lohren</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> <i>330X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertension</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 29, 1960</i> , to <i>Nov 30, 1960</i> , that I last saw the deceased alive on <i>Nov 29, 1960</i> , and that death occurred at <i>8:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard A Fitzgerald</i> M.D.		ADDRESS (Street, city or town, state) <i>217 University Blvd E Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Bernard A Fitzgerald</i>		DATE SIGNED <i>11-30-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>11/30/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 2 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hara</i>	

STATE OF NEW YORK
CERTIFICATE OF DEATH

1912

Dec. 11, 1912
New York City
John J. [Name]
[Address]
[Occupation]
[Cause of Death]
[Signature]
[Signature]
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

12712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12709

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK</u>				c. LENGTH OF STAY IN 1b <u>9 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>41</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>4101 Everett St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MARY</u>		First <u>(NMN)</u> Middle <u>Field</u> Last		4. DATE OF DEATH <u>11/26/60</u>		Month <u>11</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/85</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>I 110</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMT.</u>	
13. FATHER'S NAME <u>FRANK Kosnick</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Records</u> Address <u>pt Chart Washington Sanitarium Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Occlusion - Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerosis</u> } DUE TO <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>? years</u> <u>? years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 <u>to Nov 26</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> 19 <u>60</u> , and that death occurred at <u>4:20 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A Hare, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Robert A Hare M.D.</u>				22d. ADDRESS <u>809 Davis Ave, Takoma Park, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1951

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and to any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12710

12713

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Ola Fincham</u>		4. DATE OF DEATH <u>11 19 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
13. FATHER'S NAME <u>Ray C. Gooding</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE M. NEWLON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Cerebellar infarction and necrosis</u> DUE TO (b) <u>Rt cerebellar arterial occlusion</u> DUE TO (c) <u>Cerebellar arterial sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 days</u> <u>years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marked pulmonary atelectasis - Pelvic Surgery 11-17-60</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10-1960</u> to <u>11-19-1960</u> , that (I) (we) last saw the deceased alive on <u>11-19-1960</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Read N. Calvert, M.D.</u>		22b. DATE SIGNED <u>11-19-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>		22d. ADDRESS <u>7894 Georgia Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. POMPHREY, INC.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12714 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> d. STREET ADDRESS <u>2029 Rittenhouse St.</u>			
3. NAME OF DECEASED (Type or print) <u>Carl Dotterer Foreman</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 18, 1900</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Weapons</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>ALBERT FOREMAN</u>		14. MOTHER'S MARDEN NAME <u>MARTHA DOTTERER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Edla Foreman</u> Address <u>West Hyattsville, 2029 Rittenhouse St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
21. ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-11-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Mem. Cem. Hyattsville, Md.</u>			
22d. LOCATION (City, town, or country) <u> </u> (State) <u> </u>		23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>					
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>		DATE <u>NOV 14 '60</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH
STATE OF NEW YORK
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH
STATE OF NEW YORK
COUNTY OF NEW YORK
CITY AND COUNTY OF NEW YORK

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG279 1-16-61 et

Reg. Dist. No.

12712

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 da.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u>		b. COUNTY <u>Warren</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterlick</u>		d. STREET ADDRESS <u>Rt. 2, R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Roger Royce Frederick</u>		4. DATE OF DEATH <u>Nov. 3</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1924</u>		9. AGE (In years last birthday) <u>36</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Fredrick</u>		14. MOTHER'S MAIDEN NAME <u>Dellinger</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1941-45</u>		17. INFORMANT <u>Barbara Drederick, wife, as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapontine hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall from ladder</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>27 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Skull fracture with subdural and epidural hematoma. Epilepsy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported to have fallen from ladder while painting</u>																	
20c. TIME OF INJURY Month <u>Nov</u> Year <u>1960</u> Hour <u>3:15</u> a. m. <u>3:15</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>																	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bedg.</u>		20f. (City or town) <u>Washington D.C.</u>																	
20g. (County) <u>Bedg.</u>		20h. (State) <u>Washington D.C.</u>																	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-4-60</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/60</u>																	
22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) <u>Strasburg, Va.</u>																	
22e. (State) <u>Strasburg, Va.</u>		22f. (County) <u>Strasburg, Va.</u>																	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hester</u>		ADDRESS <u>Strasburg, Va.</u>																	
24a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hester</u>																	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH

NOTE: This certificate should be executed within 24 hours after death. If any physician is necessary, the physician should be the attending physician. Give Pages 1, 2, and 3 to the funeral director. Page 4 retained for your files. State Board of Health.

5 TO DEPU

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12713

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Md.			
c. LENGTH OF STAY IN 1b 12 hrs.				d. STREET ADDRESS 2118 Ravenswood Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bernard Mason Funk, Sr.				4. DATE OF DEATH Month 11 Day 1 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25/18	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master gas fitter				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Fred Funk FREDERICK FUNK				14. MOTHER'S MAIDEN NAME A. Dora Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW #2				16. SOCIAL SECURITY NO. 577-12-7593		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bullet wound in skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 13 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound in right skull			
20c. TIME OF INJURY Month, Day, Year Hour 10:25 10/31 19 60 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) son's home		20f. (City or town) (County) (State) West Hyatts. P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart,				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 11/1/60			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/4/60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. <i>Raymond L. Ziska</i>				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE NOV 7 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Please execute the certificate, writing
4 should be forwarded to the Chief Medical
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12794 Items 11, 12 Film 275 11-22-60 et

12714

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb - - -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4548 Windsor Lane, Bethesda, Md.		d. STREET ADDRESS 4548 Windsor Lane, 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle A Last GARDNER		4. DATE OF DEATH Month NOVEMBER Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist (Retired)		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Unhappy Chamberlain, S.D.		12. CITIZEN OF WHAT COUNTRY? - U.S.A.	
13. FATHER'S NAME Charles Gardner		14. MOTHER'S MAIDEN NAME Julia M. Brackett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 578-48-7426	
17. INFORMANT Remsen B. Ogilby (Attorney)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vessel Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia Left - 1953			
INTERVAL BETWEEN ONSET AND DEATH 6 Days 7 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1, 1953 to Nov. 15, 1960 that (I) (we) last saw the deceased alive on Nov. 12, 1960 and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank S. Bacon		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANK S. BACON		22d. ADDRESS 1150 CONN. AVE. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11-18-1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudin, Inc.		25a. REC'D BY REGISTRAR NOV 17 '60	
ADDRESS 1756 Park Ave. N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE Charles E. Hume	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12755

12715

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7708 Fortune Terrace</u>		d. STREET ADDRESS <u>7708 Fortune Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BEALL</u> Last <u>GARRETT</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/75</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Aleinda Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>McKendree G. Fulks</u>		Rt. # <u> </u> Address <u>Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Chronic bronchitis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fracture left femur - (fell in room)</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> <u>Dec. 22 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville, Montgomery Co., Md.</u>	
21. I certify that I attended the deceased from <u>about 1940</u> to <u>Nov. 11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Nov. 10</u> , 19 <u>60</u> , and that death occurred at <u>5:15 PM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>110 S. Washington St. Rockville, Md.</u>	
ACTUAL SIGNATURE <u>W. A. Linthicum</u>		DATE SIGNED <u>11/11/60</u>	
PHYSICIAN'S NAME (Type) <u>William A. Linthicum</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wagon Wheeler Funeral Home</u> <u>331 E. Montgomery Ave., Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12716

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16550 Emory Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Andrew First Middle Last Gaul				4. DATE OF DEATH Nov. Month 29 Day Year 60 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Gaul				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 121 18 0706		17. INFORMANT Katherine Mather Address Same As 2	
18. CAUSE OF DEATH [Enter only one code per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Carcinoma of prostate with metastases Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/26 to 11/29 , 19 60 , that (I) (we) last saw the deceased alive on 11/29 , and that death occurred at 8:30 A , from the causes and on the date stated above.							
22a. SIGNATURE C. H. Ligon				22b. DATE SIGNED 11/29/60			
22c. PHYSICIAN'S NAME (Type) C. H. Ligon				22d. ADDRESS Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Dec. 2 1960		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Park		23d. LOCATION (City, town, or county) (State) Hackensack New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.				25a. REC'D BY REGISTRAR DATE DEC 1 '60		25b. REGISTRAR'S SIGNATURE Charles S. K...	

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

12717

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Nebraska b. COUNTY 47X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5441 Nebraska Ave. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Althea Woodland		d. STREET ADDRESS Washington, D. C.	
3. NAME OF DECEASED (Type or print) Ethel First Middle Last Gauntlett		4. DATE OF DEATH Month 11 Day 21 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct-5-1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 21 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Great Britain	
13. FATHER'S NAME Charles Gauntlett		14. MOTHER'S MAIDEN NAME Georgiana Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT MR. JOHN A. FRANCIS (NEPHEW) Address N.W.-WASH. D.C. 5441-NEBRASKA AVE,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			INTERVAL BETWEEN ONSET AND DEATH 7 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 18, 1945 to Nov. 21, 1960 that I last saw the deceased alive on Nov. 19, 1960 , and that death occurred at 10:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Wildman, M.D. M.D.		ADDRESS (Street, city or town, state) 3729 Morrison St. N.W. DATE SIGNED 11-21-60	
PHYSICIAN'S NAME (Type) Thomas A. Wildman M.D.		Washington 15, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/23/1960	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOY COMPANY		24a. REC'D BY REGISTRAR NOV 28 1960 24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL DEPT. OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12718				
12796										CERTIFICATE OF DEATH				
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>			c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Nursing Home</u>					d. STREET ADDRESS <u>408 Mulberry St</u>									
3. NAME OF DECEASED (Type or print) <u>Eliya Jane Gibson</u>					4. DATE OF DEATH <u>November 15 1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14-15-90</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Dorsey B Mayers</u>					14. MOTHER'S MAIDEN NAME <u>Jane Boyd</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>215-26-3747</u>					INFORMANT <u>Lillian Powell</u> Address <u>Oakcrest, Laurel, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia</u> DUE TO (c) <u>arteriosclerotic Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>60</u> , to <u>Nov 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>60</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Melba L. Sewell</u> M.D. <u>Norbeck</u> PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u> <u>Rt 1, Hilroy Spring, Md.</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Nov 18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beecham Chapel</u>			22d. LOCATION (City, town, or county) (State) <u>Anne arundel Co / Md</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u>					ADDRESS <u>502 4th St Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Evans</u>					

1914

DEPARTMENT OF HEALTH

ISSUE

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NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

12684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12719

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>				d. STREET ADDRESS <u>1509 Gallatin St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary Frances Gibson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/70</u>	
9. AGE (In years lost birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>				13. FATHER'S NAME <u>William Hault</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mrs. Gordon Gibson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Debilitation</u> DUE TO <u>Anorexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Senile Deterioration</u> DUE TO <u>Senile Deterioration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>60</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I attended the deceased from <u>Jan 19 60</u> to <u>Nov 16 60</u> , that I last saw the deceased alive on <u>Nov 16 60</u> , and that death occurred at <u>11:00a</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>10609 Concord Street</u>			
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u>				DATE SIGNED <u>Nov 16, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>				<u>Kensington, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>11/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ingersoll Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ontario, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12884

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH

Washington, D.C.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12797

CERTIFICATE OF DEATH

12720

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 414 E. DIAMOND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GLADYS LUCY GILLIAM				4. DATE OF DEATH Month Day Year NOVEMBER 18 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1890		9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHNSON K. LILLY				14. MOTHER'S MAIDEN NAME ALLIE GORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-07-8230		INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Boeck's Sarcoid DUE TO Pulmonary Tuberculosis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arrested. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Bronchial Asthma, Hypertrophic Arthritis						INTERVAL BETWEEN ONSET AND DEATH Months Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. , 19 60 , to Nov. 18 , 19 60 , that I last saw the deceased alive on Nov. 18 , 19 60 , and that death occurred at 7:55 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher		ADDRESS (Street, city or town, state) 105 Russell Ave. Gaithersburg, Md.					
DATE SIGNED 11-19-60							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-60		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Francis L. Paul				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

10

12798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland Md Silver Spring.		c. LENGTH OF STAY IN 1b 3Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nursing Home.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary J Middle Goodwine Last 		4. DATE OF DEATH Month 11 / Day 11 / Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 21
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		12. KIND OF BUSINESS OR INDUSTRY Home	
13. BIRTHPLACE (State or foreign country) Ind.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Moore		16. MOTHER'S MAIDEN NAME Unknown	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. No	
19. INFORMANT Mrs William Scull		Address 2901 Allison St, Mt Rainier Md	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOCLEROTIC HEART DIS. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			INTERVAL BETWEEN ONSET AND DEATH 4 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOV. 11, 1956 to NOV. 11, 1960 , that I last saw the deceased alive on NOV. 11, 1960 , and that death occurred at 1230 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE P. L. Tabb, M.D.		ADDRESS (Street, city or town, state) 13000 GA. AVE - S.S. 178.	
PHYSICIAN'S NAME (Type) S. L. TABB, M.D.		DATE SIGNED 11/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/60	22c. NAME OF CEMETERY OR CREMATORY Tallulah Louisiana	22d. LOCATION (City, town, or county) (State) Louisiana
23. FUNERAL DIRECTOR'S SIGNATURE W. K. Huntemann & Son		24. REGISTRAR'S SIGNATURE Clifford S. Haines	
ADDRESS Washington, D. C.		DATE NOV 14 '60	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK

1878

IN SENATE

January 1, 1878

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

IN

RESPONSE TO A

RESOLUTION

PASSED

APRIL 1, 1877

AND

APPROVED

BY THE SENATE

APRIL 1, 1878

ALBANY:

W. H. BROWN,

PRINTED BY

THE STATE

OF NEW YORK

1878

ALBANY:

W. H. BROWN,

PRINTED BY

THE STATE

OF NEW YORK

1878

ALBANY:

W. H. BROWN,

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

12685
MONTGOMERY
12722
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE md b. COUNTY monty	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 4 yrs		d. STREET ADDRESS 2316 Rose Rd	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2316 Rose Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Max Gordon		4. DATE OF DEATH Nov 20 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-13
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking lot operator		11. BIRTHPLACE (State or foreign country) B. Africa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Gordon	
14. MOTHER'S MAIDEN NAME Molly Kline		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Joe Gordon (brother)	
16. SOCIAL SECURITY NO. 1619 Noyes Dr Silver Spring md		17. INFORMANT Joe Gordon (brother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) History of previous coronary attack			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschant		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschant		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 21, 1960	
22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		22d. LOCATION (City, town, or country) (State) FALLS CHURCH VA.	
23. FUNERAL DIRECTOR BERNARD DANZANSKY SONS - 3501-14th St N.W.		24e. REC'D BY REGISTRAR NOV 22 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12723

12686

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 36 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON-SILVER SPRING NURSING HOME				d. STREET ADDRESS 1 3219 DECATUR STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DAVID BRAINARD GOTTWALS			4. DATE OF DEATH Month NOV. Day 21 Year 19 60				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/58		9. AGE (In years last birthday) 102 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER - Self-employed			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HANOVER, CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ABRAHAM Z. GOTTWALS				14. MOTHER'S MAIDEN NAME MARY WAGNEST unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Spanish American None		17. INFORMANT Address Mrs. Esther G. Crandall, 2500 Upton St., N.W. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute cardiac lesion DUE TO (b) Thrombosed atherosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 30 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-14-1960 to 11-21-1960 that (I) (we) last saw the deceased alive on 11-17-1960 , and that death occurred at 11-21-1960 M, from the causes and on the date stated above.							
22a. SIGNATURE John S. Rogers				22b. DATE SIGNED 11-21-60		22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS	
22d. ADDRESS				22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/25/60		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond A. Jaska</i>				25a. REC'D BY REGISTRAR DATE NOV 28 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 6275 11-28-60 et

12724

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND Olney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		d. STREET ADDRESS RFD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PATRICIA Middle S. Last GOW		4. DATE OF DEATH Month NOV. Day 15 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/86
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Stirling		14. MOTHER'S MAIDEN NAME Elizabeth Rae	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Harry P. Dodge, Route 1, Olney, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinsonism 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 11/15 , 19 60 , that (I) (we) last saw the deceased alive on 11/8 , 19 60 , and that death occurred at 230A M, from the causes and on the date stated above.			
22a. SIGNATURE C. H. H. [Signature]		22b. DATE SIGNED 11/16/60	
22c. PHYSICIAN'S NAME (Type) C. H. H. [Signature]		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 11/18/60	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. [Signature]		25a. REC'D BY REGISTRAR NOV 22 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA
AND THE CITY OF WASHINGTON

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12726

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1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE ALTHEA WOODLAND				d. STREET ADDRESS 18501 GARLAND AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALFRED First		Middle GRAF Last		4. DATE OF DEATH 11 Month 24 Day 1960 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-83		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DR of BROADCASTING		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME AUGUST GRAF				14. MOTHER'S MAIDEN NAME HENRIETTA MEMMERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) Hypertension & Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 MOS. 5 MOS. ? years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Nov. 24, 1960 that (I) (we) last saw the deceased alive on Nov 23 1960 and that death occurred at 9 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Hare				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-24-60	
22c. PHYSICIAN'S NAME (Type) Dr. Robt. A. Hare				22d. ADDRESS 809 Davis Ave. Takoma Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
CREMATION		25 Nov. 1960		LEE CREMATORY		WASHINGTON D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME				ADDRESS 816 H ST. N.E. DC		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
						25b. REGISTRAR'S SIGNATURE Clifton S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12802 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12728

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>60 Bethesda</u> 17 Potomac	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8604 Brickyard Rd</u>		d. STREET ADDRESS <u>18604 Brickyard Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robin Lee Griffith</u>		4. DATE OF DEATH <u>nov 4 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Betty Bowser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Betty Griffith (mother)</u>		Address <u>Steu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>fund death in bed</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2074282XV4

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

Robert A. Humphrey, Bethesda, Maryland, May 10, 1911
Buried Cedar Hill Cemetery, Suitland, Maryland

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1305 U Street, S.E. Apt. 103 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lily Staples HAESLOOP				4. DATE OF DEATH Month Day Year November 2 19 60			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-89	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ebert STAPLES				14. MOTHER'S MAIDEN NAME Mamie LAWLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, intracerebral, spontaneous, left (Massive) DUE TO Conditions, if any, which gave rise to immediate cause (b) Atheresclerosis, generalized causing the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Found unconscious on floor at home, apparently fallen preparing for bed.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. Appr. 11-2 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Washington, D.C.	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
DATE SIGNED 11-3-60							
ACTUAL SIGNATURE Frank J. Broschart M.D.							
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.							
Address (Street, city, town, or county) Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-7-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or country) Arlington	(State) Virginia			
23. FUNERAL DIRECTOR ADDRESS Lee Funeral Home, 4th & Mass, Ave.NW, WashDC							
24a. REC'D BY REGISTRAR DATE NOV 7 '60			24b. REGISTRAR'S SIGNATURE Arthur L. Hanes				

12804

CERTIFICATE OF DEATH

Reg. Dist. No.

12730

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Poolesville, Md c. LENGTH OF STAY in 1b life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willard Rd, Poolesville, Md d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA First NAOMI Middle HALL Last		4. DATE OF DEATH Month November Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1895 9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME William Bussey	
14. MOTHER'S MAIDEN NAME Idella Lee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. INFORMANT		Address Miss Bertha Hall - Poolesville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary embolism DUE TO (c) metastatic carcinoma DUE TO carcinoma of the liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 months 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1955, to Nov. 16 , 1960, that I last saw the deceased alive on Nov 16 , 1960, and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) P.O. Box D, Md DATE SIGNED 11/16/60 ACTUAL SIGNATURE John L. ... M.D. Dawsonville PHYSICIAN'S NAME (Type) P.O. Box D, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11/19/60	Warren Chapel	Martinsburg, Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sunderlock		24a. REC'D BY REGISTRAR DATE NOV 22 '60	
ADDRESS Sunderlock, Md		24b. REGISTRAR'S SIGNATURE Charles L. ...	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DEPT.

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or its certification agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 4 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Michigan b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Inkster d. STREET ADDRESS 28433 Oakwood Avenue 59X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Dewitt Clinton HAMEL		4. DATE OF DEATH Month November Day 8 Year 19 60		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-26		9. AGE (In years last birthday) 33 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) Michigan				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. HAMEL						14. MOTHER'S MAIDEN NAME Marie MEADE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1945 to DOD				16. SOCIAL SECURITY NO. 369-22-3408		17. INFORMANT Address Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transection of spinal cord at C3-4 region DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Comminuted fracture of cervical vertebrae DUE TO (c) Automobile accident												INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): headon collision. Driver of car which left road and overturned attempting to avoid												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Street-Rt. 222 Aiken Cecil Maryland									
20c. TIME OF INJURY Month, Day, Year 11-3-60			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street-Rt. 222			20f. (City or town) (County) (State) Aiken Cecil Maryland					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11-9-60					
EXAMINER'S NAME (Type) Frank J. BROSCHART, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipments				22b. DATE THEREOF 11-10-60		22c. NAME OF CEMETERY OR CREMATORY Detroit Michigan				22d. LOCATION (City, town, or country) (State) Detroit Michigan			
23. FUNERAL DIRECTOR W.W. Chambers, 1400 Chapin St., NW, WashDC						24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE <i>C. J. L. Smith</i>					

MEDICAL CERTIFICATION

CONFIDENTIAL

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FRANK J. BRONKHORST, M.D.

10:55

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12806

12732

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>478 Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>7104-146 street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles R. Hargett</i>		4. DATE OF DEATH Month Day Year <i>Nov. 2 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/24/03</i>
9. AGE (In years lost birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Investigator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lawyer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles A. Hargett</i>		14. MOTHER'S MAIDEN NAME <i>Clara Richter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>578-05-4454</i>	
17. INFORMANT <i>Roland H. Hargett</i>		Address <i>8011-Watkins Bethesda, md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Acute Posterior Myocardial Infarction</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>11/27 1960</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/28 1960</i> to <i>11/2 1960</i> , that (I) (we) last saw the deceased alive on <i>11/27 1960</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul D. Cantor</i>		22b. DATE SIGNED <i>11/2/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Paul D. Cantor</i>		22d. ADDRESS <i>4709 Montgomery Lane - Bethesda</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/5/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Harris</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	
DATE <i>NOV 4 '60</i>			

CERTIFICATE OF DEATH

15200

1

Paul D. Carter

Frederick, Maryland

11/2/50

Robert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12716

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12753

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium/Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Eugene Harris</u>		4. DATE OF DEATH <u>November 6, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1894</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>5</u> Hours <u>1</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Controller - U.S. Govt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. States</u>	
13. FATHER'S NAME <u>Kenneth W Harris</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Honeycutt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war and dates of service) <u>YES WWT Army</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Kenneth Harris</u>		Address <u>(Same address)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal Obstruction</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Tumor of Lung</u> DUE TO (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/7, 1960</u> , to <u>11/6, 1960</u> , that (I) (we) last saw the deceased alive on <u>11/6, 1960</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		22d. ADDRESS <u>7600 Carroll Avenue, Maryland Takoma Park,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. ...</u>		25a. RECEIVED BY REGISTRAR <u>NOV 9 1960</u>	
ADDRESS <u>2901-14 ...</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

12516

CERTIFICATE OF DEATH

1. Name of deceased: William J. Harris
2. Date of death: Nov 14 1922
3. Place of death: Home
4. Age: 68
5. Sex: Male
6. Race: White
7. Cause of death: Heart
8. Signature of physician: W. J. Harris
9. Signature of registrar: W. J. Harris
10. Date of registration: Nov 14 1922
11. Place of registration: Home
12. Name of registrar: W. J. Harris
13. Signature of informant: W. J. Harris
14. Date of information: Nov 14 1922
15. Place of information: Home
16. Name of informant: W. J. Harris
17. Signature of informant: W. J. Harris
18. Date of signature: Nov 14 1922
19. Place of signature: Home
20. Name of signature: W. J. Harris

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12807

CERTIFICATE OF DEATH

Reg. Dist. No.

12734

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Bethesda	
c. LENGTH OF STAY IN 1b 2 wks		d. STREET ADDRESS 5714 Kingswood Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brown Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle A. Last HARRISON		4. DATE OF DEATH Month NOV. Day 11, Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1884
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer --retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Reuben Harrison		14. MOTHER'S MAIDEN NAME Christina Gosnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-14-7628	
17. INFORMANT T. Woodrow Harrison, R.D 7 Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:47 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. M. Van Poole M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Winfield, Md. 11-15-60	
PHYSICIAN'S NAME (Type) C. M. Van Poole			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-14-1960	22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel	22d. LOCATION (City, town, or county) (State) Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE NOV 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12735

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9908 MARKHAM STREET		d. STREET ADDRESS 9908 MARKHAM STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAYMOND C HENDERSON		4. DATE OF DEATH Month NOV. Day 18 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/98	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal Property Assessor Mont. Co. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) US.A.	
13. FATHER'S NAME JAMES HENDERSON		14. MOTHER'S MAIDEN NAME ROBERTA unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW # 1		16. SOCIAL SECURITY NO. 218-26-5348		17. INFORMANT Address Mrs. Mary W. Henderson, 9908 Markham St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Silver Spring, Maryland PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Silver Spring, Maryland	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/19/60	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/22/60	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPNEY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR NOV 28 1960	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12746

12736

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4025 Glenridge Road		d. STREET ADDRESS 4025 Glenrdige Road	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Hendry		4. DATE OF DEATH Month Nov. Day 10 Year 19 60	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 5 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Walter A. England		14. MOTHER'S MAIDEN NAME Temple Hood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walton Hendry-Husband-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1 19 60 to Nov 10 19 60 that (I) (we) lost the deceased on Nov 8 19 60 , and that death occurred at 2 A. M. from the causes on and on the date stated above.			
22a. SIGNATURE Wilfred R. Ehrmantraut		22b. DATE SIGNED 11/10/60	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		22d. ADDRESS 4890 Battery Lane, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE NOV 14 '60	

12346

CERTIFICATE OF STATE

Washington

U.S. DEPT. OF AGRICULTURE

WEEKLY REPORT

WEEK ENDING MAY 11, 1901

WEEK ENDING MAY 18, 1901

WEEK ENDING MAY 25, 1901

WEEK ENDING JUNE 1, 1901

WEEK ENDING JUNE 8, 1901

WEEK ENDING JUNE 15, 1901

WEEK ENDING JUNE 22, 1901

WEEK ENDING JUNE 29, 1901

WEEK ENDING JULY 6, 1901

WEEK ENDING JULY 13, 1901

WEEK ENDING JULY 20, 1901

WEEK ENDING JULY 27, 1901

WEEK ENDING AUGUST 3, 1901

WEEK ENDING AUGUST 10, 1901

WEEK ENDING AUGUST 17, 1901

WEEK ENDING AUGUST 24, 1901

WEEK ENDING AUGUST 31, 1901

12747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12737**

FOR STATE
 HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Monty	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3414 Dupont Ave		d. STREET ADDRESS 3414 Dupont Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Joseph Henahan First Middle Last		4. DATE OF DEATH Month Nov Day 22 Year 1960	
5. SEX male	6. COLOR OR RACE white	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-31 9. AGE (In years last birthday) 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tree expert		10b. KIND OF BUSINESS OR INDUSTRY Pa 11. BIRTHPLACE (State or foreign country) Pa	
13. FATHER'S NAME Michael Henahan		14. MOTHER'S MAIDEN NAME Anna Jennie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Korean War		16. SOCIAL SECURITY NO. 192-24-9437 17. INFORMANT J. J. Henahan - Address Stur 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, bilateral, severe DUE TO 812 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pressure c. cerebellum DUE TO (c) Fracture, old, orbital plate, left frontal bone PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Nov 8-21 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Wheaton Monty md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-23-60	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11/28/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS 1331 E. Montg. Ave., Rockville, Md.		24a. REC'D BY REGISTRAR NOV 28 60 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Item 20 Film 275 11-29-60</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> <div>12808</div> <div>CERTIFICATE OF DEATH</div> <div>12738</div>																	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Springfield</i> d. STREET ADDRESS <i>15623 Ogden Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <i>Robert Cooney Henry</i>			First <i>Robert</i> Middle <i>Cooney</i> Last <i>Henry</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>10</i> Year <i>1960</i>												
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/25/1880</i>		9. AGE (In years last birthday) <i>80</i> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>M. S. Capt.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Navy Dept.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										
13. FATHER'S NAME <i>Brian Henry</i>					14. MOTHER'S MAIDEN NAME <i>Hester Cooney</i>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mary M. Beau</i> Address <i>15623 Ogden Rd. Springfield, Maryland</i>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>902.7 EMBOLUS, PULMONARY</i> DUE TO (b) <i>Fracture, (L) HIP</i> DUE TO (c) <i>ARTERIOSCLEROSIS, GENERALIZED</i> ONSET AND DEATH <i>2 HOURS</i> <i>6 DAYS</i> <i>15 YEARS</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Slipped from chair to floor</i>												
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>11-2</i> p. m. <i>40</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Conv. Home</i>		20f. (City or town) <i>Kensington</i> (County) <i>Montg</i> (State) <i>Md.</i>										
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE</i> <i>1958</i> to <i>NOV 10</i> <i>1960</i> that (I) (we) lost <i>saw the deceased alive on</i> <i>11-9</i> <i>1960</i> and that death occurred at <i>7:40 PM</i> from the causes and on the date stated above.																	
22a. SIGNATURE <i>Philip R. James</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED										
22c. PHYSICIAN'S NAME (Type) <i>Philip R. James</i>					22d. ADDRESS <i>Washington Clinic</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>11/12/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i> (State)										
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Jones Co.</i>					ADDRESS <i>2901-14th St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 14 '60</i>		25b. REGISTRAR'S SIGNATURE <i>C. J. Jones</i>								

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1930

REPUBLIC OF THE UNITED STATES OF AMERICA
DEPARTMENT OF COMMERCE
BUREAU OF MARITIME SERVICE
OFFICE OF THE MARITIME COMMISSIONER
WASHINGTON, D. C.

1930

1. Name of Vessel: *U.S.S. Albatross*

2. Type of Vessel: *U.S. Fish Commission*

3. Date of Departure: *March 1, 1930*

4. Port of Departure: *San Francisco*

5. Name of Captain: *William H. Jones*

6. Name of Commanding Officer: *William H. Jones*

7. Name of Officer in Charge: *William H. Jones*

8. Name of Engineer: *William H. Jones*

9. Name of Steward: *William H. Jones*

10. Name of Cook: *William H. Jones*

11. Name of Carpenter: *William H. Jones*

12. Name of Sailor: *William H. Jones*

13. Name of Passenger: *William H. Jones*

14. Name of Cargo: *William H. Jones*

15. Name of Freight: *William H. Jones*

16. Name of Insurance: *William H. Jones*

17. Name of Agent: *William H. Jones*

18. Name of Broker: *William H. Jones*

19. Name of Shipper: *William H. Jones*

20. Name of Receiver: *William H. Jones*

21. Name of Consignee: *William H. Jones*

22. Name of Consignor: *William H. Jones*

23. Name of Consignator: *William H. Jones*

24. Name of Consignee: *William H. Jones*

25. Name of Consignor: *William H. Jones*

26. Name of Consignator: *William H. Jones*

27. Name of Consignee: *William H. Jones*

28. Name of Consignor: *William H. Jones*

29. Name of Consignator: *William H. Jones*

30. Name of Consignee: *William H. Jones*

31. Name of Consignor: *William H. Jones*

32. Name of Consignator: *William H. Jones*

33. Name of Consignee: *William H. Jones*

34. Name of Consignor: *William H. Jones*

35. Name of Consignator: *William H. Jones*

36. Name of Consignee: *William H. Jones*

37. Name of Consignor: *William H. Jones*

38. Name of Consignator: *William H. Jones*

39. Name of Consignee: *William H. Jones*

40. Name of Consignor: *William H. Jones*

41. Name of Consignator: *William H. Jones*

42. Name of Consignee: *William H. Jones*

43. Name of Consignor: *William H. Jones*

44. Name of Consignator: *William H. Jones*

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50. Name of Consignator: *William H. Jones*

51. Name of Consignee: *William H. Jones*

52. Name of Consignor: *William H. Jones*

53. Name of Consignator: *William H. Jones*

54. Name of Consignee: *William H. Jones*

55. Name of Consignor: *William H. Jones*

56. Name of Consignator: *William H. Jones*

57. Name of Consignee: *William H. Jones*

58. Name of Consignor: *William H. Jones*

59. Name of Consignator: *William H. Jones*

60. Name of Consignee: *William H. Jones*

61. Name of Consignor: *William H. Jones*

62. Name of Consignator: *William H. Jones*

63. Name of Consignee: *William H. Jones*

64. Name of Consignor: *William H. Jones*

65. Name of Consignator: *William H. Jones*

66. Name of Consignee: *William H. Jones*

67. Name of Consignor: *William H. Jones*

68. Name of Consignator: *William H. Jones*

69. Name of Consignee: *William H. Jones*

70. Name of Consignor: *William H. Jones*

71. Name of Consignator: *William H. Jones*

72. Name of Consignee: *William H. Jones*

73. Name of Consignor: *William H. Jones*

74. Name of Consignator: *William H. Jones*

75. Name of Consignee: *William H. Jones*

76. Name of Consignor: *William H. Jones*

77. Name of Consignator: *William H. Jones*

78. Name of Consignee: *William H. Jones*

79. Name of Consignor: *William H. Jones*

80. Name of Consignator: *William H. Jones*

81. Name of Consignee: *William H. Jones*

82. Name of Consignor: *William H. Jones*

83. Name of Consignator: *William H. Jones*

84. Name of Consignee: *William H. Jones*

85. Name of Consignor: *William H. Jones*

86. Name of Consignator: *William H. Jones*

87. Name of Consignee: *William H. Jones*

88. Name of Consignor: *William H. Jones*

89. Name of Consignator: *William H. Jones*

90. Name of Consignee: *William H. Jones*

91. Name of Consignor: *William H. Jones*

92. Name of Consignator: *William H. Jones*

93. Name of Consignee: *William H. Jones*

94. Name of Consignor: *William H. Jones*

95. Name of Consignator: *William H. Jones*

96. Name of Consignee: *William H. Jones*

97. Name of Consignor: *William H. Jones*

98. Name of Consignator: *William H. Jones*

99. Name of Consignee: *William H. Jones*

100. Name of Consignor: *William H. Jones*

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12809

12739

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7200 Seven Locks Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Reather Mary Louise Herbert</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1960</u>		5. AGE (In years last birthday) yrs. <u>1</u> Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1960</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>60</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Junior Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Irene Bradley Herbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>475X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>Burial</u>		<u>11/30/60</u>		<u>Lincoln Park</u>		<u>Rockville Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Jenkins</u>				ADDRESS <u>Rockville, Md.</u>		24e. REC'D BY REGISTRAR <u>DEC 5 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

MEDICAL CERTIFICATION

18203

THE
UNITED STATES

NOV 11 1930

RECEIVED

NOV 11 1930



Handwritten notes at the bottom of the page, including "11/11/30" and "11/11/30".

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12810

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12740

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>R. Hermsdorf</i> Last <i></i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5/6/18</i>
9. AGE (In years last birthday) <i>42 yrs.</i>		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>consultant for Govt</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Dept.</i>	11. BIRTHPLACE (State or foreign country) <i>New Hampshire</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Kurt Hermsdorf</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Masur</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	
16. SOCIAL SECURITY NO. <i>112-05-8102</i>		17. INFORMANT Address <i>Johanna Hermsdorf-wife-same 2d</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>153.3</i> DUE TO <i>Pulmonary embolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>Pulmonary embolism</i> (c) <i>Sigmoid carcinoma with metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i> <i>6 hours</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>FEB 18 60</i> to <i>NOV 4 1960</i> and that (I) (we) last saw the deceased alive on <i>Nov 4 1960</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. O'Connor</i> M.D.		22b. DATE SIGNED <i>11/4/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>THOMAS F. O'CONNOR M.D.</i>		22d. ADDRESS <i>4861 BATTERY LANE BETHESDA 14, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/8/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 9 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

15810

STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

15810

(1)

Johnna Harrison Wilson

1885-1905

Robert A. Harrison, Registrar, Division of Vital Records, State Department of Health

Robert A. Harrison, Registrar, Division of Vital Records, State Department of Health

CERTIFICATE OF DEATH

Reg. Dist. No.

12741

12811

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS Hunting Towers, Center Bldg., Apt. 703 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Devlin Raymond Hewitt				4. DATE OF DEATH Month Day Year November 27, 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1936	
9. AGE (In years lost birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician				10b. KIND OF BUSINESS OR INDUSTRY Analytic services		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph J. Hewitt				14. MOTHER'S MAIDEN NAME Millie Massey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 248-50-9444			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pancytopenia with Bone Marrow Failure, Hepatic Failure							
INTERVAL BETWEEN ONSET AND DEATH 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 2, 1960 , to November 27, 1960 that I last saw the deceased alive on November 27, 1960 , and that death occurred at 12:55 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-28-60							
ACTUAL SIGNATURE Jerome B. Block				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit				22b. DATE THEREOF 12/4/60			
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) (State) Marion, South Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR DEC 1 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12811

Nationalist
 Joseph J. ...
 Virginia
 May 12, 1930
 U.S.A.

Joseph J. ...
 The National ...
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November 17, 1930
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12812

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12742

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2904 Garfield Terrace, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Allen Middle HOBBBS Last HOBBBS			4. DATE OF DEATH Month November Day 23 Year 1960		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-99	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Alexander HOBBBS		
14. MOTHER'S MAIDEN NAME Louise ALLEN			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. 1916 to 1953			17. INFORMANT (W) Mrs. Fayette L. P. Hobbs, same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes 8 yrs.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Nov. 12 1960 to Nov. 23 1960	(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 12 1960 to Nov. 23 1960 , that (I) (we) last saw the deceased alive on Nov. 23 1960 , and that death occurred at 12 PM , from the causes and on the date stated above.					
22a. SIGNATURE F. H. O'Connell		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-23-60	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-28-60	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town, or county) (State) Arlington Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Penn. Ave. NW, Wash DC		25a. RECEIVED BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12815

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

REGISTRATION

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LOCAL

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DATE OF DEATH

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PLACE OF DEATH

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DEATH CERTIFICATE NO. ()

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VS A15 (4)
ISM 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12743	
12813											
CERTIFICATE OF DEATH											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson (Rural) c. LENGTH OF STAY IN 1b (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peach Tree Road.,					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson (Rural) d. STREET ADDRESS Peach Tree Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First PERCIVAL Middle J. Last HONEMOND					4. DATE OF DEATH Month Nov. Day 14. Year 19 60						
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1875		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Josiah Honemond					14. MOTHER'S MAIDEN NAME Sarah Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		INFORMANT Sarah Honemond Address Peach Tree Rd., Dickerson, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cerebral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Disease										INTERVAL BETWEEN ONSET AND DEATH 11 days 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 Nov , 19 60 , to 14 Nov , 19 60 , that I last saw the deceased alive on 14 November, 19 60 , and that death occurred at 4:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 14 Nov 60 ACTUAL SIGNATURE Gordon M. Smith M.D. PHYSICIAN'S NAME (Type) Gordon M. Smith											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11/18/60		22c. NAME OF CEMETERY OR CREMATORY Jerusalem Baptist.,			22d. LOCATION (City, town, or county) (State) Poolesville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suowden					ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE NOV 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 14, 22c & d, File G274 11/18/60 iwk

Reg. Dist. No.

12744

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>off Sunshine - Brighton Road</u>		d. STREET ADDRESS <u>650 1/2 NEWTON ST., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>LOUISE</u> Last <u>HORNE</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>5</u> Year <u>1960 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/25</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GENERAL LEE COOK</u>		14. MOTHER'S MAIDEN NAME <u>Bradshaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO <u>981X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of aorta</u> DUE TO (c) <u>Bullet wound</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in woods along side of Sunshine - Brighton Road</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u>nr Sunshine Montg. Mdd.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-15-60</u>		22b. DATE THEREOF <u>11-15-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Horton</u> ADDRESS <u>1314 1/2 Jan. St. N.W.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

DATE SIGNED

11/6/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. COLOR		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. DISEASE		13. INJURY		14. POISON		15. OTHER	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF CLERK		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF MINISTER		24. SIGNATURE OF CHURCH		25. SIGNATURE OF FUNERAL HOME	
26. SIGNATURE OF BURIAL PLACE		27. SIGNATURE OF INTERMENT		28. SIGNATURE OF CEMETERY		29. SIGNATURE OF GRAVE		30. SIGNATURE OF MONUMENT	
31. SIGNATURE OF RECORDS		32. SIGNATURE OF VITALS		33. SIGNATURE OF STATISTICS		34. SIGNATURE OF DEATH		35. SIGNATURE OF LIFE	
36. SIGNATURE OF MARRIAGE		37. SIGNATURE OF DIVORCE		38. SIGNATURE OF ANNUITY		39. SIGNATURE OF PROBATE		40. SIGNATURE OF ESTATE	
41. SIGNATURE OF TRUST		42. SIGNATURE OF GUARDIAN		43. SIGNATURE OF CURATOR		44. SIGNATURE OF ADMINISTRATOR		45. SIGNATURE OF EXECUTOR	
46. SIGNATURE OF FIDELITY		47. SIGNATURE OF BOND		48. SIGNATURE OF SURETY		49. SIGNATURE OF JUDICIAL		50. SIGNATURE OF LEGAL	
51. SIGNATURE OF COURT		52. SIGNATURE OF JURY		53. SIGNATURE OF VERDICT		54. SIGNATURE OF FINDING		55. SIGNATURE OF CONCLUSION	
56. SIGNATURE OF RECOMMENDATION		57. SIGNATURE OF ADVICE		58. SIGNATURE OF COUNSEL		59. SIGNATURE OF OPINION		60. SIGNATURE OF DECISION	
61. SIGNATURE OF ORDER		62. SIGNATURE OF WRIT		63. SIGNATURE OF PROCESS		64. SIGNATURE OF RETURN		65. SIGNATURE OF COMPLAINT	
66. SIGNATURE OF PETITION		67. SIGNATURE OF ANSWER		68. SIGNATURE OF MOTION		69. SIGNATURE OF OBJECTION		70. SIGNATURE OF EXCEPTION	
71. SIGNATURE OF DEMURRER		72. SIGNATURE OF VERIFICATION		73. SIGNATURE OF AFFIDAVIT		74. SIGNATURE OF SUBPOENA		75. SIGNATURE OF RETURN	
76. SIGNATURE OF EXHIBIT		77. SIGNATURE OF DEPOSITION		78. SIGNATURE OF INTERVIEW		79. SIGNATURE OF EXAMINATION		80. SIGNATURE OF TESTIMONY	
81. SIGNATURE OF EVIDENCE		82. SIGNATURE OF PROSECUTION		83. SIGNATURE OF DEFENSE		84. SIGNATURE OF JURY		85. SIGNATURE OF VERDICT	
86. SIGNATURE OF FINDING		87. SIGNATURE OF CONCLUSION		88. SIGNATURE OF RECOMMENDATION		89. SIGNATURE OF ADVICE		90. SIGNATURE OF COUNSEL	
91. SIGNATURE OF OPINION		92. SIGNATURE OF DECISION		93. SIGNATURE OF ORDER		94. SIGNATURE OF WRIT		95. SIGNATURE OF PROCESS	
96. SIGNATURE OF RETURN		97. SIGNATURE OF COMPLAINT		98. SIGNATURE OF PETITION		99. SIGNATURE OF ANSWER		100. SIGNATURE OF MOTION	
101. SIGNATURE OF OBJECTION		102. SIGNATURE OF EXCEPTION		103. SIGNATURE OF DEMURRER		104. SIGNATURE OF VERIFICATION		105. SIGNATURE OF AFFIDAVIT	
106. SIGNATURE OF SUBPOENA		107. SIGNATURE OF RETURN		108. SIGNATURE OF EXHIBIT		109. SIGNATURE OF DEPOSITION		110. SIGNATURE OF INTERVIEW	
111. SIGNATURE OF EXAMINATION		112. SIGNATURE OF TESTIMONY		113. SIGNATURE OF EVIDENCE		114. SIGNATURE OF PROSECUTION		115. SIGNATURE OF DEFENSE	
116. SIGNATURE OF JURY		117. SIGNATURE OF VERDICT		118. SIGNATURE OF FINDING		119. SIGNATURE OF CONCLUSION		120. SIGNATURE OF RECOMMENDATION	
121. SIGNATURE OF ADVICE		122. SIGNATURE OF COUNSEL		123. SIGNATURE OF OPINION		124. SIGNATURE OF DECISION		125. SIGNATURE OF ORDER	
126. SIGNATURE OF WRIT		127. SIGNATURE OF PROCESS		128. SIGNATURE OF RETURN		129. SIGNATURE OF COMPLAINT		130. SIGNATURE OF PETITION	
131. SIGNATURE OF ANSWER		132. SIGNATURE OF MOTION		133. SIGNATURE OF OBJECTION		134. SIGNATURE OF EXCEPTION		135. SIGNATURE OF DEMURRER	
136. SIGNATURE OF VERIFICATION		137. SIGNATURE OF AFFIDAVIT		138. SIGNATURE OF SUBPOENA		139. SIGNATURE OF RETURN		140. SIGNATURE OF EXHIBIT	
141. SIGNATURE OF DEPOSITION		142. SIGNATURE OF INTERVIEW		143. SIGNATURE OF EXAMINATION		144. SIGNATURE OF TESTIMONY		145. SIGNATURE OF EVIDENCE	
146. SIGNATURE OF PROSECUTION		147. SIGNATURE OF DEFENSE		148. SIGNATURE OF JURY		149. SIGNATURE OF VERDICT		150. SIGNATURE OF FINDING	
151. SIGNATURE OF CONCLUSION		152. SIGNATURE OF RECOMMENDATION		153. SIGNATURE OF ADVICE		154. SIGNATURE OF COUNSEL		155. SIGNATURE OF OPINION	
156. SIGNATURE OF DECISION		157. SIGNATURE OF ORDER		158. SIGNATURE OF WRIT		159. SIGNATURE OF PROCESS		160. SIGNATURE OF RETURN	
161. SIGNATURE OF COMPLAINT		162. SIGNATURE OF PETITION		163. SIGNATURE OF ANSWER		164. SIGNATURE OF MOTION		165. SIGNATURE OF OBJECTION	
166. SIGNATURE OF EXCEPTION		167. SIGNATURE OF DEMURRER		168. SIGNATURE OF VERIFICATION		169. SIGNATURE OF AFFIDAVIT		170. SIGNATURE OF SUBPOENA	
171. SIGNATURE OF RETURN		172. SIGNATURE OF EXHIBIT		173. SIGNATURE OF DEPOSITION		174. SIGNATURE OF INTERVIEW		175. SIGNATURE OF EXAMINATION	
176. SIGNATURE OF TESTIMONY		177. SIGNATURE OF EVIDENCE		178. SIGNATURE OF PROSECUTION		179. SIGNATURE OF DEFENSE		180. SIGNATURE OF JURY	
181. SIGNATURE OF VERDICT		182. SIGNATURE OF FINDING		183. SIGNATURE OF CONCLUSION		184. SIGNATURE OF RECOMMENDATION		185. SIGNATURE OF ADVICE	
186. SIGNATURE OF COUNSEL		187. SIGNATURE OF OPINION		188. SIGNATURE OF DECISION		189. SIGNATURE OF ORDER		190. SIGNATURE OF WRIT	
191. SIGNATURE OF PROCESS		192. SIGNATURE OF RETURN		193. SIGNATURE OF COMPLAINT		194. SIGNATURE OF PETITION		195. SIGNATURE OF ANSWER	
196. SIGNATURE OF MOTION		197. SIGNATURE OF OBJECTION		198. SIGNATURE OF EXCEPTION		199. SIGNATURE OF DEMURRER		200. SIGNATURE OF VERIFICATION	
201. SIGNATURE OF AFFIDAVIT		202. SIGNATURE OF SUBPOENA		203. SIGNATURE OF RETURN		204. SIGNATURE OF EXHIBIT		205. SIGNATURE OF DEPOSITION	
206. SIGNATURE OF INTERVIEW		207. SIGNATURE OF EXAMINATION		208. SIGNATURE OF TESTIMONY		209. SIGNATURE OF EVIDENCE		210. SIGNATURE OF PROSECUTION	
211. SIGNATURE OF DEFENSE		212. SIGNATURE OF JURY		213. SIGNATURE OF VERDICT		214. SIGNATURE OF FINDING		215. SIGNATURE OF CONCLUSION	
216. SIGNATURE OF RECOMMENDATION		217. SIGNATURE OF ADVICE		218. SIGNATURE OF COUNSEL		219. SIGNATURE OF OPINION		220. SIGNATURE OF DECISION	
221. SIGNATURE OF ORDER		222. SIGNATURE OF WRIT		223. SIGNATURE OF PROCESS		224. SIGNATURE OF RETURN		225. SIGNATURE OF COMPLAINT	
226. SIGNATURE OF PETITION		227. SIGNATURE OF ANSWER		228. SIGNATURE OF MOTION		229. SIGNATURE OF OBJECTION		230. SIGNATURE OF EXCEPTION	
231. SIGNATURE OF DEMURRER		232. SIGNATURE OF VERIFICATION		233. SIGNATURE OF AFFIDAVIT		234. SIGNATURE OF SUBPOENA		235. SIGNATURE OF RETURN	
236. SIGNATURE OF EXHIBIT		237. SIGNATURE OF DEPOSITION		238. SIGNATURE OF INTERVIEW		239. SIGNATURE OF EXAMINATION		240. SIGNATURE OF TESTIMONY	
241. SIGNATURE OF EVIDENCE		242. SIGNATURE OF PROSECUTION		243. SIGNATURE OF DEFENSE		244. SIGNATURE OF JURY		245. SIGNATURE OF VERDICT	
246. SIGNATURE OF FINDING		247. SIGNATURE OF CONCLUSION		248. SIGNATURE OF RECOMMENDATION		249. SIGNATURE OF ADVICE		250. SIGNATURE OF COUNSEL	
251. SIGNATURE OF OPINION		252. SIGNATURE OF DECISION		253. SIGNATURE OF ORDER		254. SIGNATURE OF WRIT		255. SIGNATURE OF PROCESS	
256. SIGNATURE OF RETURN		257. SIGNATURE OF COMPLAINT		258. SIGNATURE OF PETITION		259. SIGNATURE OF ANSWER		260. SIGNATURE OF MOTION	
261. SIGNATURE OF OBJECTION		262. SIGNATURE OF EXCEPTION		263. SIGNATURE OF DEMURRER		264. SIGNATURE OF VERIFICATION		265. SIGNATURE OF AFFIDAVIT	
266. SIGNATURE OF SUBPOENA		267. SIGNATURE OF RETURN		268. SIGNATURE OF EXHIBIT		269. SIGNATURE OF DEPOSITION		270. SIGNATURE OF INTERVIEW	
271. SIGNATURE OF EXAMINATION		272. SIGNATURE OF TESTIMONY		273. SIGNATURE OF EVIDENCE		274. SIGNATURE OF PROSECUTION		275. SIGNATURE OF DEFENSE	
276. SIGNATURE OF JURY		277. SIGNATURE OF VERDICT		278. SIGNATURE OF FINDING		279. SIGNATURE OF CONCLUSION		280. SIGNATURE OF RECOMMENDATION	
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291. SIGNATURE OF ANSWER		292. SIGNATURE OF MOTION		293. SIGNATURE OF OBJECTION		294. SIGNATURE OF EXCEPTION		295. SIGNATURE OF DEMURRER	
296. SIGNATURE OF VERIFICATION		297. SIGNATURE OF AFFIDAVIT		298. SIGNATURE OF SUBPOENA		299. SIGNATURE OF RETURN		300. SIGNATURE OF EXHIBIT	
301. SIGNATURE OF DEPOSITION		302. SIGNATURE OF INTERVIEW		303. SIGNATURE OF EXAMINATION		304. SIGNATURE OF TESTIMONY		305. SIGNATURE OF EVIDENCE	
306. SIGNATURE OF PROSECUTION		307. SIGNATURE OF DEFENSE		308. SIGNATURE OF JURY		309. SIGNATURE OF VERDICT		310. SIGNATURE OF FINDING	
311. SIGNATURE OF CONCLUSION		312. SIGNATURE OF RECOMMENDATION		313. SIGNATURE OF ADVICE		314. SIGNATURE OF COUNSEL		315. SIGNATURE OF OPINION	
316. SIGNATURE OF DECISION		317. SIGNATURE OF ORDER		318. SIGNATURE OF WRIT		319. SIGNATURE OF PROCESS		320. SIGNATURE OF RETURN	
321. SIGNATURE OF COMPLAINT		322. SIGNATURE OF PETITION		323. SIGNATURE OF ANSWER		324. SIGNATURE OF MOTION		325. SIGNATURE OF OBJECTION	
326. SIGNATURE OF EXCEPTION		327. SIGNATURE OF DEMURRER		328. SIGNATURE OF VERIFICATION		329. SIGNATURE OF AFFIDAVIT		330. SIGNATURE OF SUBPOENA	
331. SIGNATURE OF RETURN		332. SIGNATURE OF EXHIBIT		333. SIGNATURE OF DEPOSITION		334. SIGNATURE OF INTERVIEW		335. SIGNATURE OF EXAMINATION	
336. SIGNATURE OF TESTIMONY		337. SIGNATURE OF EVIDENCE		338. SIGNATURE OF PROSECUTION		339. SIGNATURE OF DEFENSE		340. SIGNATURE OF JURY	
341. SIGNATURE OF VERDICT		342. SIGNATURE OF FINDING		343. SIGNATURE OF CONCLUSION		344. SIGNATURE OF RECOMMENDATION		345. SIGNATURE OF ADVICE	
346. SIGNATURE OF COUNSEL		347. SIGNATURE OF OPINION		348. SIGNATURE OF DECISION		349. SIGNATURE OF ORDER		350. SIGNATURE OF WRIT	
351. SIGNATURE OF PROCESS		352. SIGNATURE OF RETURN		353. SIGNATURE OF COMPLAINT		354. SIGNATURE OF PETITION		355. SIGNATURE OF ANSWER	
356. SIGNATURE OF MOTION		357. SIGNATURE OF OBJECTION		358. SIGNATURE OF EXCEPTION		359. SIGNATURE OF DEMURRER		360. SIGNATURE OF VERIFICATION	
361. SIGNATURE OF AFFIDAVIT		362. SIGNATURE OF SUBPOENA		363. SIGNATURE OF RETURN		364. SIGNATURE OF EXHIBIT		365. SIGNATURE OF DEPOSITION	
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371. SIGNATURE OF DEFENSE		372. SIGNATURE OF JURY		373. SIGNATURE OF VERDICT		374. SIGNATURE OF FINDING		375. SIGNATURE OF CONCLUSION	
376. SIGNATURE OF RECOMMENDATION		377. SIGNATURE OF ADVICE		378. SIGNATURE OF COUNSEL		379. SIGNATURE OF OPINION		380. SIGNATURE OF DECISION	
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401. SIGNATURE OF EVIDENCE		402. SIGNATURE OF PROSECUTION		403. SIGNATURE OF DEFENSE		404. SIGNATURE OF JURY		405. SIGNATURE OF VERDICT	
406. SIGNATURE OF FINDING		407. SIGNATURE OF CONCLUSION		408. SIGNATURE OF RECOMMENDATION		409. SIGNATURE OF ADVICE		410. SIGNATURE OF COUNSEL	
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471. SIGNATURE OF CONCLUSION		472. SIGNATURE OF RECOMMENDATION		473. SIGNATURE OF ADVICE		474. SIGNATURE OF COUNSEL		475. SIGNATURE OF OPINION	
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491. SIGNATURE OF RETURN		492. SIGNATURE OF EXHIBIT		493. SIGNATURE OF DEPOSITION		494. SIGNATURE OF INTERVIEW		495. SIGNATURE OF EXAMINATION	
496. SIGNATURE OF TESTIMONY		497. SIGNATURE OF EVIDENCE		498. SIGNATURE OF PROSECUTION		499. SIGNATURE OF DEFENSE		500. SIGNATURE OF JURY	
501. SIGNATURE OF VERDICT		502. SIGNATURE OF FINDING		503. SIGNATURE OF CONCLUSION		504. SIGNATURE OF RECOMMENDATION		505. SIGNATURE OF ADVICE	
506. SIGNATURE OF COUNSEL		507. SIGNATURE OF OPINION		508. SIGNATURE OF DECISION		509. SIGNATURE OF ORDER		510. SIGNATURE OF WRIT	
511. SIGNATURE OF PROCESS		512. SIGNATURE OF RETURN		513. SIGNATURE OF COMPLAINT		514. SIGNATURE OF PETITION		515. SIGNATURE OF ANSWER	
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521. SIGNATURE OF AFFIDAVIT		522. SIGNATURE OF SUBPOENA		523. SIGNATURE OF RETURN		524. SIGNATURE OF EXHIBIT		525. SIGNATURE OF DEPOSITION	
526. SIGNATURE OF INTERVIEW		527. SIGNATURE OF EXAMINATION		528. SIGNATURE OF TESTIMONY		529. SIGNATURE OF EVIDENCE		530. SIGNATURE OF PROSECUTION	
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536. SIGNATURE OF RECOMMENDATION		537. SIGNATURE OF ADVICE		538. SIGNATURE OF COUNSEL		539. SIGNATURE OF OPINION		540. SIGNATURE OF DECISION	
541. SIGNATURE OF ORDER		542. SIGNATURE OF WRIT		543. SIGNATURE OF PROCESS		544. SIGNATURE OF RETURN		545. SIGNATURE OF COMPLAINT	
546. SIGNATURE OF PETITION		547. SIGNATURE OF ANSWER		548. SIGNATURE OF MOTION		549. SIGNATURE OF OBJECTION		550. SIGNATURE OF EXCEPTION	
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566. SIGNATURE OF FINDING		567. SIGNATURE OF CONCLUSION		568. SIGNATURE OF RECOMMENDATION		569. SIGNATURE OF ADVICE		570. SIGNATURE OF COUNSEL	
571. SIGNATURE OF OPINION		572. SIGNATURE OF DECISION		573. SIGNATURE OF ORDER		574. SIGNATURE OF WRIT		575. SIGNATURE OF PROCESS	
576. SIGNATURE OF RETURN		577. SIGNATURE OF COMPLAINT		578. SIGNATURE OF PETITION		579. SIGNATURE OF ANSWER		580. SIGNATURE OF MOTION	
581. SIGNATURE OF OBJECTION		582. SIGNATURE OF EXCEPTION		583. SIGNATURE OF DEMURRER		584. SIGNATURE OF VERIFICATION		585. SIGNATURE OF AFFIDAVIT	
586. SIGNATURE OF SUBPOENA		587. SIGNATURE OF RETURN		588. SIGNATURE OF EXHIBIT		589. SIGNATURE OF DEPOSITION		590. SIGNATURE OF INTERVIEW	
591. SIGNATURE OF EXAMINATION		592. SIGNATURE OF TESTIMONY		593. SIGNATURE OF EVIDENCE		594. SIGNATURE OF PROSECUTION		595. SIGNATURE OF DEFENSE	
596. SIGNATURE OF JURY		597. SIGNATURE OF VERDICT		598. SIGNATURE OF FINDING		599. SIGNATURE OF CONCLUSION		600. SIGNATURE OF RECOMMENDATION	
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611. SIGNATURE OF ANSWER		612. SIGNATURE OF MOTION		613. SIGNATURE OF OBJECTION		614. SIGNATURE OF EXCEPTION		615. SIGNATURE OF DEMURRER	
616. SIGNATURE OF VERIFICATION		617. SIGNATURE OF AFFIDAVIT		618. SIGNATURE OF SUBPOENA		619. SIGNATURE OF RETURN		620. SIGNATURE OF EXHIBIT	
621. SIGNATURE OF DEPOSITION		622. SIGNATURE OF INTERVIEW		623. SIGNATURE OF EXAMINATION		624. SIGNATURE OF TESTIMONY		625. SIGNATURE OF EVIDENCE	
626. SIGNATURE OF PROSECUTION		627. SIGNATURE OF DEFENSE		628. SIGNATURE OF JURY		629. SIGNATURE OF VERDICT		630. SIGNATURE OF FINDING	
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666. SIGNATURE OF COUNSEL		667. SIGNATURE OF OPINION		668. SIGNATURE OF DECISION		669. SIGNATURE OF ORDER		670. SIGNATURE OF WRIT	
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676. SIGNATURE OF MOTION		677. SIGNATURE OF OBJECTION		678. SIGNATURE OF EXCEPTION		679. SIGNATURE OF DEMURRER		680. SIGNATURE OF VERIFICATION	
681. SIGNATURE OF AFFIDAVIT		682. SIGN							

TO HOSPITAL BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12815
CERTIFICATE OF DEATH

12745

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 14303 Knowles Ave.	
3. NAME OF DECEASED (Type or print) Bertha First A. Middle Hughes Last		4. DATE OF DEATH 11/18/ Month 1960 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/78
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Appleby		14. MOTHER'S MAIDEN NAME Augusta Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen Prevail Daughter Same as Above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Aortic Aneurysm, Abdominal DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6.00 Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 6, 1944 to Nov. 18, 1960 that (I) (we) last saw the deceased alive on Nov. 18, 1960 and that death occurred at 1233 , from the causes and on the date stated above.			
22a. SIGNATURE Katharine A. Chapman M.D.		22b. DATE SIGNED 11/18/60	
22c. PHYSICIAN'S NAME (Type) Katharine Chapman		22d. ADDRESS 3924 Baltimore St. Kensington, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/60	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 22 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

STATE OF NEW YORK

1881

Montgomery

Sanborn

Southard

Seelye

For Sale

Office Address

John

No

1881

302 Baltimore St. Lexington, Va.

1881 11/21/80

Robert A. Montgomery

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12689

12746

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2702 FENIMORE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JESSE BOWLES HUGHES SR.		4. DATE OF DEATH Month NOV. Day 6 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/08
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Supervisor		10b. KIND OF BUSINESS OR INDUSTRY American Citizens Insurance Co.	
11. BIRTHPLACE (State or foreign country) Orange County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GEORGE HUGHES		14. MOTHER'S MAIDEN NAME LAURA PAYNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-32-2171	
17. INFORMANT Mrs. Georgia A. Hughes, 2702 Fenimore Road		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3 19 53 to Nov 19 60 that (I) (we) last saw the deceased alive on Nov 19 60 and that death occurred at 44M from the causes and on the date stated above.			
22a. SIGNATURE John J. Curry		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY		22d. ADDRESS 10620 Georgia Ave. Ind	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/9/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond C. Jones		25a. REC'D BY REGISTRAR DATE NOV 14 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

13083

Blank certificate form with faint horizontal lines and a large circular watermark in the center.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12747

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
c. LENGTH OF STAY IN 1b <u>5 yrs</u>			d. STREET ADDRESS <u>1808 McAuliffe Dr</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1808 McAuliffe Dr</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Quentin Edmund Hulse</u>			4. DATE OF DEATH <u>Nov 27 1960</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-16-26</u>		
9. AGE (in years last birthday) <u>34</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>			12. KIND OF BUSINESS OR INDUSTRY <u>M.S. Gov.</u>		
13. BIRTHPLACE (State or foreign country) <u>Ila</u>			14. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
15. FATHER'S NAME <u>Charles C. Hulse</u>			16. MOTHER'S MAIDEN NAME <u>Ruth C. Altwig</u>		
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW 2</u>			18. SOCIAL SECURITY NO. <u>Unknown</u>		
19. INFORMANT <u>Richard E. Hulse</u>			20. ADDRESS <u>1806 McAuliffe Dr Rockville md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema - bilateral</u>					
322.0 DUE TO (b) <u>Aspiration of gastric contents</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Acute alcoholism</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>11/30/60</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			ADDRESS <u>Bethesda, Maryland</u>		
24a. REC'D BY REGISTRAR <u>Nov 29 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13710

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible] years
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]
15. Registrar's office: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12749

12817

1. PLACE OF DEATH a. COUNTY Montgomery M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia C COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, d. STREET ADDRESS 1734 Potomac Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Lee Roy Last HUTCHESON				4. DATE OF DEATH Month November Day 22 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-26-89	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. HUTCHESON				14. MOTHER'S MAIDEN NAME Jane DENNY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Naval Air Sta. (S) Fred D. Hutcheson, YN3, USNR, Miramar, Calif.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 min. years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 5 1:30 PM to Nov. 22 1960 , that (I) (we) last saw the deceased alive on Nov. 22 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE J. E. Spitcher		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-23-60			
22c. PHYSICIAN'S NAME (Type) J. E. SPITCHER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 11th St. SE, WashDC				25a. REC'D BY REGISTRAR NOV 28 1960 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1881

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12818

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12750

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 757B MEMQ, Naval Air Station	
3. NAME OF DECEASED (Type or print) First James Middle Allen Last JOHNSON		4. DATE OF DEATH Month November Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 October 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	9. AGE (In years last birthday) 13 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William B. JOHNSON		14. MOTHER'S MAIDEN NAME Carolyn COOPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NA	
17. INFORMANT William B. JOHNSON		Address 757B MEMQ NAS Patuxent River, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BACTEREMIA UNKNOWN ETIOLOGY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-7 19 60 to 11-11 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-11 19 60 , and that death occurred at 4:40 AM the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack		22b. DATE SIGNED 11 November 1960	
22c. PHYSICIAN'S NAME (Type) R. V. RACK, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-12-60	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Great Mills Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robinson's Funeral Home, Leonardtown, Md.		25a. REC'D BY REGISTRAR NOV 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2051355XV5

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12819 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12751

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>4826 Del Ray Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4826 Del Ray Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Katherine Jones</u>		4. DATE OF DEATH <u>Nov 2 1960</u>		5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-60</u>		9. AGE (In years last birthday) <u>4</u> yrs. <u>5</u> months <u>2</u> days <u>19</u> hours		10. IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe Jones</u>				14. MOTHER'S MAIDEN NAME <u>Educa Poore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joe Jones (father)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Asphyxia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Final death in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	
22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>				22e. REC'D BY REGISTRAR			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				23a. ADDRESS <u>Bethesda, Maryland</u>		23b. REGISTRAR'S SIGNATURE <u>Clotilde S. Harris</u>	
23c. NAME (Type) <u>Frank J. Broschart</u>				23d. DATE <u>NOV 4 '60</u>		23e. DATE SIGNED <u>11-2-60</u>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

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1881 MEDICAL EXAMINER'S CERTIFICATE OF HEALTH

State of Virginia
County of Albemarle
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that
the within and above named person is a free person, of the age of
years, and of the color of
and that he or she is free from all diseases, and is in good health,
and is capable of performing all the duties of a soldier, sailor, or
mariner, and is fit for service in the military, naval, or marine
service of the United States.

Witness my hand and seal this _____ day of _____, 1881.

Medical Examiner

Robert A. Humphrey, Surgeon, U.S. Army.
Arlington, Virginia.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12752

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8317 Takoma Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Christian</u> Last <u>Juel</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-05</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Serv. Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hicks Chevrolet</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Juel</u>		14. MOTHER'S MAIDEN NAME <u>Mary? Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Edna C. Juel</u>		Address <u>8317 Takoma Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> DUE TO <u>976X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound thru skull</u> (c) <u> </u> DUE TO <u> </u> cause lost. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>self-inflicted bullet wound thru skull</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> a.m. <u> </u> p.m. <u> </u> <u>11-3 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring Montg Md</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 8 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Deal</u>		ADDRESS <u>Funeral Home 4812 Ga. Ave</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

DATE NOV 14 '60

12820

CERTIFICATE OF DEATH

12753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vinnia Middle Dell Last Karnes				4. DATE OF DEATH Month November Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1905	
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 13 Hours 13 Min.		11. IF UNDER 24 HRS. Months 5 Days 13 Hours 13 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming house owner				10b. KIND OF BUSINESS OR INDUSTRY Hostelry			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jasper N. Benson				14. MOTHER'S MAIDEN NAME Mary E. Welcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 579-48-4745			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cardiovascular Collapse DUE TO (c) ? Septicemia and Pulmonary Atelectasis Bilateral PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-operative (4 days) total pelvic exenteration and construction of ileal loop bladder							
INTERVAL BETWEEN ONSET AND DEATH 2 Hours 11 Hours 11 Hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) loop bladder		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 19		(County)		(State)	
21. I certify that I attended the deceased from November 2, 1960 to November 26, 1960 , that I last saw the deceased alive on November 26, 1960 , and that death occurred at 5:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/26/60 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE George F. Miller, Jr. M.D. The Clinical Center 11/26/60 PHYSICIAN'S NAME (Type) George F. Miller Jr. M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec 2, 1960		T		Alderson, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517-11th St. SE Wash, D.C.		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15850

STATE OF OHIO

County of Cuyahoga

Washington

1909 & 1910, 1911

James

July 13, 1907

Virginia

Harry H. Nelson

The Medical Record

1907-1911, The Clinical Record, February 11, 1911

James H. Nelson

Notes on the history of the

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12754

12690

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Sanitarium 11901 Ga. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Sullivan</u> Last <u>Karney</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE (In years last birthday) yrs. <u>87</u>
11. BIRTHPLACE (State or foreign country) <u>Detroit, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sulkivan</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Edwin Stohlman, Sr.</u>		Address <u>Chevy Chase Md. 4815 Essex Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, severe</u> DUE TO (c) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour <u>None</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) <u>Nov.</u> (County) (State)
21. I certify that I attended the deceased from <u>Aug. 16</u> to <u>Sept. 15, 1960</u> , that I last saw the deceased alive on <u>November 13, 1960</u> , and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Argonne Apts.</u> DATE SIGNED <u>9/15/60</u>			
ACTUAL SIGNATURE <u>George Dewey</u> M.D.		PHYSICIAN'S NAME (Type) <u>George Dewey, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-18-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elliott Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Detroit, MICHIGAN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		ADDRESS <u>2224 - Wis. Ave</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4 copies

12821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12755

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac (Rural)				c. LENGTH OF STAY IN 1b 48 4703 Chase Avenue, Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home				d. STREET ADDRESS 4703 Chase Avenue			
3. NAME OF DECEASED (Type or print) First Katherine Middle V Last Keim				4. DATE OF DEATH Month Nov. Day 26 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1868		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 5 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress maker-ret		10b. KIND OF BUSINESS OR INDUSTRY Sewing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Keim				14. MOTHER'S MAIDEN NAME Magdalene (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Peter Haley, Neice-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 days. 2 mos. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile cachexia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 16, 1946 to Nov. 26, 1960 , that (I) (we) last saw the deceased alive on Nov. 19, 1960 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A.J. Connolly				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/26/60	
22c. PHYSICIAN'S NAME (Type) A.J. CONNOLLY-M.D.				22d. ADDRESS 1635 IRVING ST. N.W. WASH 16, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 29 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thane			

7911-112 2-21-05

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12756

12718

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 53 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8403 SLIGO CREEK PARKWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ANN KING				4. DATE OF DEATH Month Day Year NOVEMBER 27, 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 11, 1878	
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) KING GEORGE CO, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME PATRICK H. PAYNE				14. MOTHER'S MAIDEN NAME AGNES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HARRY W. KING Address 8403 SLIGO CREEK PARKWAY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 day ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1947 to 27 Nov 1960 , that (I) (we) last saw the deceased alive on 27 Nov 1960 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William D. Aud				22b. DATE SIGNED 11/27/60		22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD	
22d. ADDRESS 9006 COLESVILLE ROAD, SILVER SPRING				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/27/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town, or county) (State) SUHLAND, MARYLAND MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters ADDRESS 254 CARROLL ST. NW-DC				25a. REC'D BY REGISTRAR NOV 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1871

STATE OF OHIO

1871

1



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

12719

12757

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12th and 10th St. - Home Park Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. San. Hosp.</u>		d. STREET ADDRESS <u>4611-13 St.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mrs. Lucy Ada Kink</u>		4. DATE OF DEATH <u>11/10/60</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-78</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		
13. FATHER'S NAME <u>Henry Houser</u>		14. MOTHER'S MAIDEN NAME <u>Emma Collins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not known</u>		
17. INFORMANT <u>Chark</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of rt. breast</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-26-</u> <u>1958</u> , to <u>Nov. 10, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19 <u>60</u> , and that death occurred at <u>9:20</u> AM, from the causes and on the date stated above.				
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>11/10/60</u>		
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI, M.D.</u>		22d. ADDRESS <u>918 Univ. Blvd. E. Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/12/60</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Churchyard Cem. Potomac, Md.</u>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hume Co. 2901 14th N.W.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 '60</u>		
25b. REGISTRAR'S SIGNATURE <u>Clara S. Hume</u>				

CERTIFICATE OF DEATH

1871

MASSACHUSETTS

John P. Smith

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

John P. Smith

1871

12738

CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4904 Cumberland Avenue		e. STREET ADDRESS 4904 Cumberland Avenue	
3. NAME OF DECEASED (Type or print) First TATIANA Middle V Last KUSHNAREFF		4. DATE OF DEATH Month Nov. Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 9 Days 3	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? STATELESS	
13. FATHER'S NAME Vassily (Unknown)		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
INFORMANT Katherine Krynitsky-daughter-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subarachnoid Hemorrhage - DUE TO (c) Generalized Arterio Sclerosis -		INTERVAL BETWEEN ONSET AND DEATH 24 hr. 5 days 20 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) osteo arthritis - severe -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Nov. , 1960, to 9 Nov. , 1960 that I last saw the deceased alive on 8 Nov. , 1960, and that death occurred at 5 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Ball		ADDRESS (Street, city or town, state) 7936 Georgetown Rd. 9 Nov 60	
PHYSICIAN'S NAME (Type) John G. Ball		M.D. Bethesda 14 md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12/60	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

CERTIFICATE OF DEATH

John G. Bell

4500 Cambridge Avenue

TATIANA

Female White

Nonsey

Female (Unknown)

John G. Bell

John G. Bell

April 11 1938

Robert A. Langley

CERTIFICATE OF DEATH

Reg. Dist. No.

12759

12822

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 229 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY Washington, D.C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 1373 Downing Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		3. NAME OF DECEASED (Type or print) First John		Middle Daniel		Last Lewis, Jr.		4. DATE OF DEATH Month November		Day 27		Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1955		9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 4		Hours 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John D. Lewis, Sr.		14. MOTHER'S MAIDEN NAME Helen Ware													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Osteomyelitis of Face DUE TO (c) Acute Lymphatic Leukemia														INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D.C.		(County) Washington		(State) D.C.					
21. I certify that I attended the deceased from April 12, 1960 to November 27, 1960 that I last saw the deceased alive on November 27, 1960 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE Edward E. Morse		M.D. The Clinical Center		DATE SIGNED 11/28/60											
PHYSICIAN'S NAME (Type) Edward E. Morse, MD															
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 3, 1960		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) Washington, D.C.		(State) D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, 389 R.J. Ave. N.W.		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DEC 1 '60		24b. REGISTRAR'S SIGNATURE Robert L. Kipard									

State of Colorado

Health Dept., D.C.

1913 January 25th, 1913

John D. Lewis, Jr.

December 2, 1912

Washington, D.C.

John D. Lewis, Jr.

The National Bureau of Health
The National Bureau of Health

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The National Bureau of Health
The National Bureau of Health

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
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VR A15 (4)
ISM 9/59

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Page 4

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12823

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12760

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 20 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 300 CALVIN LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma A Middle Logan Last Logan				4. DATE OF DEATH Month Nov. Day 7 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1874	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months 36 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 36 Days 10 Hours 10 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady	
10b. KIND OF BUSINESS OR INDUSTRY Phil. Pa				11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN LOGAN				14. MOTHER'S MAIDEN NAME MARGARET KENNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NIECE. (MRS. MARTIN BURKE)		17. INFORMANT Address NIECE. (MRS. MARTIN BURKE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) PULMONARY EMBOLUS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CHRONIC COR PULMONALE (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 26 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 36 Hours 10 years 26 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 30, 1960 , to November 7, 1960 , that (I) (we) last saw the deceased alive on Nov. 6, 1960 , and that death occurred 11:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Gordon S. Rosenberg				22b. DATE SIGNED NOV 9 1960		22c. ADDRESS 31020 Montgomery Ave. Rockville, Md.	
22d. PHYSICIAN'S NAME (Type) GORDON S. ROSENBERG				22e. ADDRESS 31020 Montgomery Ave. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				24a. ADDRESS 1331 E. Montgomery Avenue Rockville, Md.		24b. REC'D BY REGISTRAR DATE NOV 9 '60	
24c. REGISTRAR'S SIGNATURE Gordon S. Rosenberg				24d. REGISTRAR'S SIGNATURE Gordon S. Rosenberg			

1994-1995

1525

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12761

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN Tn <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>			d. STREET ADDRESS <u>2407 Spencer Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Franklin Samuel Long</u>			4. DATE OF DEATH Month Day Year <u>November 5 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-76</u>		9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - patent examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>XXXXXXXXXX Ephraim Long</u>			14. MOTHER'S MAIDEN NAME <u>Mary Kirkham</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-34-6268</u>		17. INFORMANT Address <u>Mrs. Hazel Roth (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> 204-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Leukemia</u> (c) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>several weeks</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11/4/1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/13/1960</u> to <u>11/5/1960</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>11/4/1960</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.					
22a. SIGNATURE <u>Donald Nelson</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat. Mem. Park</u>	
23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	

1875

CERTIFICATE OF DEATH

1875

State of Maryland, County of Prince George's, City of Washington, D. C.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

on the _____ day of _____, 1875, at _____, in the County of _____, State of _____, I attended _____, who died of _____

at the age of _____ years, and that the death was caused by _____

and that the death was not caused by any contagious or infectious disease, or by any other cause than that stated above.

I have signed this certificate as a true and correct statement of the facts as stated above.

Witness my hand and seal this _____ day of _____, 1875.

Physician

Deputy Registrar

Registrar

Clerk

Notary Public

Minister of the Gospel

Justice of the Peace

Mayor

Recorder

Treasurer

Comptroller

Assessor

Surveyor

Coroner

Sheriff

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12721 Item 22d, Film G274 11/17/60 iwk 12762
MONTGOMERY
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK.</u>	
c. LENGTH OF STAY IN 1b <u>11 YRS.</u>		d. STREET ADDRESS <u>8007-WILLOWOOD DRIVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8007-WILLOWOOD DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OWEN</u> Middle <u>P.</u> Last <u>LONG</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEER</u>	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES LONG</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE RILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>JUSAN LONG-8007-WILLOWOOD DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma stomach primary</u> DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Nov. 4</u> , 1960, that I last saw the deceased alive on <u>Nov. 3</u> , 1960, and that death occurred at <u>1:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.W. Smith</u>		ADDRESS (Street, city or town, state) <u>13018 GEORGIA AVE.</u>	
PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>		DATE SIGNED <u>11/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 11-7-60</u>		22b. DATE THEREOF <u>11-7-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thermyth Hanlon</u>		ADDRESS <u>3831 La Ave NW</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824

CERTIFICATE OF DEATH

12763

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7801 Maple Ridge Road		d. STREET ADDRESS 7801 Maple Ridge Road	
3. NAME OF DECEASED (Type or print) First Emma Middle H Last Looker		4. DATE OF DEATH Month November Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 2 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Houchen		14. MOTHER'S MAIDEN NAME Amanda Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT R. B. Looker-husband-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 27, 1960 , to Nov 21, 1960 , that I last saw the deceased alive on Nov 20, 1960 , and that death occurred at 8:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave., Kensington, Md. DATE SIGNED 11/21/60			
ACTUAL SIGNATURE George Sharpe		PHYSICIAN'S NAME (Type) George Sharpe M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 23 60		24b. REGISTRAR'S SIGNATURE Robert S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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12722
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12764

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D.C. b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 9 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		d. STREET ADDRESS 6209 NEBRASKA AVE NW	
3. NAME OF DECEASED (Type or print) First HARRY Middle R Last LOVELESS		4. DATE OF DEATH Month 11 Day 4 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WARREN LOVELESS		14. MOTHER'S MAIDEN NAME CARRIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes Unknown	
17. INFORMANT Hosp. Record.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10+ yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1950 to Nov 5 1960 , that (I) last saw the deceased alive on Nov 4 1960 , and that death occurred at 11 M. from the causes and on the date stated above.			
22a. SIGNATURE A. H. Richwine		22b. DATE SIGNED Nov 5, 60	
22c. PHYSICIAN'S NAME (Type) A. H. Richwine		22d. ADDRESS 5522 Western Ave, Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 11-7-60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE NOV 9 '60		25b. REGISTRAR'S SIGNATURE Charles S. Howard	

12222

CERTIFICATE OF DEATH

12th
10th

12-4 60
12-4 60

12-4 60
12-4 60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

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12691

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12765

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marle a Nursing Home				d. STREET ADDRESS 2227 Wisconsin Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle E. Last MacDonald				4. DATE OF DEATH Month Feb Day 9 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Edwards				14. MOTHER'S MAIDEN NAME --- Barker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Lois Rupert - 2227 Wisconsin Ave., N.W. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac distress DUE TO 33 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic cardiac disease DUE TO 7 years (c) longstanding arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary artery disease INTERVAL BETWEEN ONSET AND DEATH 30 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 27 1960 to Feb 9 1960 that (I) (we) last saw the deceased alive on Feb 8 1960 and that death occurred at 10 PM from the causes and on the date stated above.							
22a. SIGNATURE John S. Rogers				22b. DATE SIGNED Feb 9 1960			
22c. PHYSICIAN'S NAME (Type) John S. Rogers				22d. ADDRESS 1919 Spring Valley Rd Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR Nov 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12825
CERTIFICATE OF DEATH

12766

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAINHART Middle NELLIE Last		4. DATE OF DEATH Month NOVEMBER 11 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 10/15/1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BANDOLPH J. STUP		14. MOTHER'S MAIDEN NAME MARY ELIZABETH FLYNN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 7 hours 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) balanced senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 1960 to NOV 11 1960 , that (I) (we) last saw the deceased alive on Nov 11 1960, and that death occurred at 3:45 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 11, 1960	
22c. PHYSICIAN'S NAME (Type) GORDON S. ROSENBERGER, M. D.		22d. ADDRESS ROCKVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14 1960	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis G. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR DATE NOV 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hand	

1978

CERTIFICATE OF DEATH

12852

DATE OF DEATH: NOVEMBER 11, 1987
 TIME OF DEATH: 10:15 P.M.
 PLACE OF DEATH: HOSPITAL DOCTOR, BUREAU, HARTLAND
 DECEASED'S NAME: HANDELSON, J. STAN
 SEX: MALE
 RACE: WHITE
 AGE: 73
 BIRTH DATE: 1914
 BIRTH PLACE: U.S.A.
 MARITAL STATUS: SINGLE
 OCCUPATION: NONE
 CAUSE OF DEATH: HOSPITAL DOCTOR, BUREAU, HARTLAND
 SIGNATURE: HANDELSON, J. STAN
 DATE: NOVEMBER 11, 1987
 PLACE: HOSPITAL DOCTOR, BUREAU, HARTLAND

1978

DATE OF DEATH: NOVEMBER 11, 1987
 TIME OF DEATH: 10:15 P.M.
 PLACE OF DEATH: HOSPITAL DOCTOR, BUREAU, HARTLAND
 DECEASED'S NAME: HANDELSON, J. STAN
 SEX: MALE
 RACE: WHITE
 AGE: 73
 BIRTH DATE: 1914
 BIRTH PLACE: U.S.A.
 MARITAL STATUS: SINGLE
 OCCUPATION: NONE
 CAUSE OF DEATH: HOSPITAL DOCTOR, BUREAU, HARTLAND
 SIGNATURE: HANDELSON, J. STAN
 DATE: NOVEMBER 11, 1987
 PLACE: HOSPITAL DOCTOR, BUREAU, HARTLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12767

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash D.C.</u> b. COUNTY <u>47 X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blair</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash D.C.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>			d. STREET ADDRESS <u>4545 Conn Ave N.W.</u>		
3. NAME OF DECEASED (Type or print) <u>Philip G Mandell</u>			4. DATE OF DEATH <u>Nov 27 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 10 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Moses Mandell</u>			14. MOTHER'S MAIDEN NAME <u>Bella Spigel</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Sophie Mandell</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. } (b) <u>Uremia + Dehydrates mellitus</u> (c) <u>B.P.H</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7-Feb</u> 19 <u>60</u> to <u>27 Nov</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>27 Nov</u> 19 <u>60</u> and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>John Bosley Ziegler</u>			22b. DATE SIGNED <u>Nov. 27, 1960</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>			22d. ADDRESS <u>OLNEY MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 29, 1960</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>			23d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY</u>			25a. REC'D BY REGISTRAR <u>NOV 30 '60</u>		
ADDRESS <u>WASH. D.C.</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

1001

CERTIFICATE OF DEATH

18850

1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12827

12768

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Slater Middle Manganaro Last				4. DATE OF DEATH Month November Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-54		9. AGE (In years lost birthday) 6 yrs.	IF UNDER 1 YEAR Months 5 Days 24	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Ferdinand Manganaro				14. MOTHER'S MAIDEN NAME Carol Anne Slater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Francis F. Manganaro (F) Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vasomotor & respiratory collapse DUE TO 237X Infiltrative brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-8 19 60 to 11-12 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-12 19 60 , and that death occurred at 510AM from the causes and on the date stated above.							
22a. SIGNATURE <i>C. W. Bramlett</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-12-60	
22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Humphrey</i> R. A. Humphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE NOV 16 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

D.C.

CERTIFICATE OF DEATH

12882

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12828 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 48	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>6811 FAIRFAX RD 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EARLE ROLLINS MARDEN</u>		4. DATE OF DEATH <u>Nov. 29</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25, 1901</u> 59 yrs.
9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office RYE, New Hampshire</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES MARDEN</u>		14. MOTHER'S MAIDEN NAME <u>GRACE ROLLINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1920-22		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Velma L. Marden</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. James Co.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>	
ADDRESS <u>2901 14th NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1930

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY EXAMINATIONS

5. CAUSE OF DEATH

6. SIGNATURES

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>W.O.A</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>418 Lincoln Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Daisy ELIZABETH McCloskey</u>		4. DATE OF DEATH <u>11-21</u> 19 <u>60</u>		5. SEX <u>W</u>		6. COLOR OR RACE <u>H</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-92</u> 68 yrs.		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosp</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Charles STARK</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Lupold</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or date of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Lula G. McCloskey</u> Address <u>Same as Deceased</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-21-60</u>							
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 25, 1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Prince Georges County, Maryland</u>			
23. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll St NW. DC</u>				ADDRESS				24a. REC'D BY REGISTRAR <u>NOV 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaup</u>				DATE							

1883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH REPORT

1883

1

STATE OF NEW YORK
COUNTY OF ...
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the ... day of ... 1883, at the place above named, I examined the body of ... deceased, and found that the same had died of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12829

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12771

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist. of Co.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>	e. STREET ADDRESS <u>2226-Nickolsom St.</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion V. McDaniel</u>		4. DATE OF DEATH Month Day Year <u>Nov 4 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/24</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk-typist, U.S. Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Walter McDaniel</u>		14. MOTHER'S MAIDEN NAME <u>Jewell Bridges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Jewell Morris</u>		Address <u>2226-Nickolsom St. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Spontaneous subarachnoid hemorrhage</u> 330x DUE TO (b) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>_____</u> INTERVAL BETWEEN ONSET AND DEATH <u>11/1/60</u> <u>11/4/60</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1/60</u> to <u>11/4/60</u> that (I) (we) last saw the deceased alive on <u>11/4/60</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George A. Gray, Jr.</u>		22b. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-7-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>300-4th St. NE</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	
DATE <u>NOV 9 '60</u>			

1874

OFFICE OF THE SECRETARY OF THE TREASURY

1874

1874

1874

1874

1874

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12739

CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3805 Woodbine Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SI Cherry Chase</u> d. STREET ADDRESS <u>3805 Woodbine St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lois's Kenneth</u> First Middle Last 4. DATE OF DEATH <u>November 24</u> Month Day Year <u>1960</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 17, 1896</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>As 106</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Manufact. Agent</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset County, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>J. E. Kenneth McDorman</u> 14. MOTHER'S MAIDEN NAME <u>Mary Schwartz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>578-01-8518</u>		17. INFORMANT <u>wife, 3805 Woodbine St. Ch. Ch. Md.</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>years.</u> <u>1958</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> , to <u>Nov 24, 1960</u> , that I last saw the deceased alive on <u>October</u> , 19 <u>60</u> , and that death occurred at <u>10:00 P.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Davis Ave. Takoma Pk. Md.</u>		DATE SIGNED <u>11/24/60</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>		<u>809 Davis Ave. Tk. Pk. Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Transit</u>		22b. DATE THEREOF <u>11/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula Mem. Park</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		24c. LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12830

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12773

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle JAMES Last MCKINNEY				4. DATE OF DEATH Month NOVEMBER Day 4 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 6, 1881	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TENNESSEE	
13. FATHER'S NAME JAMES MCKINNEY				14. MOTHER'S MAIDEN NAME HATTIE ATLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Coronary heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks YRS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/4 19 60 , to 10/4 19 60 , that (I) (we) last saw the deceased alive on NOV 4 1960, and that death occurred 10:50 AM from the causes and on the date stated above.							
22a. SIGNATURE C. H. LIGON, M. D.				22b. DATE SIGNED NOV 7 '60			
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-11-60-1960 Nat'l Harmony Mem.				23b. DATE THEREOF 11-11-60			
23c. NAME OF CEMETERY OR CREMATORY Nat'l Harmony Mem.				23d. LOCATION (City, town, or county) (State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, Inc. 389 2nd St. NW				25a. REC'D BY REGISTRAR NOV 7 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1875

RECEIVED BY THE BOARD OF HEALTH
FROM THE CITY OF NEW YORK

CERTIFICATE OF DEATH

1880

NAME OF DECEASED
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF THE GOSPEL
SIGNATURE OF JURYMAN

1

John J. Smith
John J. Smith

517

11-400-014-11

1. **TO HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12774

12724

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12774

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>29</u> d. STREET ADDRESS <u>1427 Highland Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Purdy</u> Last <u>McLeod</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11/30/1898</u> <u>61</u> yrs.		9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent of Bldgs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't. C. City Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		13. FATHER'S NAME <u>E. Patton McLeod</u>		14. MOTHER'S MAIDEN NAME <u>Susan Gaillard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>217-34-1799</u>		17. INFORMANT Address <u>Wife - 1427 Highland Drive S Sp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion (thrombosis)</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u> </u> (c) <u> </u>		DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction, previous</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>Nov-15-1960</u> , that (I) (we) last saw the deceased alive on <u>Nov-15-1960</u> , and that death occurred at <u>2:52 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>James M. Whitekeels</u>		22b. DATE SIGNED <u>11/23/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITEKEELS</u>		22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/23/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond A. Jaka</u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
25c. ADDRESS <u>SILVER SPRING, MD.</u>		25d. DATE <u>NOV 28 '60</u>			

CERTIFICATE OF DEATH

1924

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Signature of informant

1

11. Name of informant
12. Address of informant
13. Signature of informant
14. Date of completion
15. Registrar's signature
16. Registrar's name
17. Registrar's address
18. Registrar's title

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12831
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12775

1. PLACE OF DEATH a. COUNTY Montgomery			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 day			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			d. STREET ADDRESS 150 Darrington St., S. W.			47 X-2		
3. NAME OF DECEASED (Type or print) First Joseph Middle Gordon Last MICHAEL			4. DATE OF DEATH Month November Day 2 Year 19 60			5. SEX Male			6. COLOR OR RACE Caucasian		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-1-60			9. AGE (In years last birthday) 1			IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -			10b. KIND OF BUSINESS OR INDUSTRY - - - - -			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Paul Gordon MICHAEL			14. MOTHER'S MAIDEN NAME Shirley Mae O'CONNOR			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT (F) Paul G. Michael, same as #2 above			Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal atelectasis, cause undetermined DUE TO (b) 762-8 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			Patent ductus arteriosus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) person attended the deceased from Nov. 1 1:45 PM to Nov. 2 1:45 PM , 19 60 , that (I) person last saw the deceased alive on Nov. 2 19 60 , and that death occurred at M , from the causes and on the date stated above.			22a. SIGNATURE Robert V. Rack		
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN			22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.			22d. DATE 11-3-60			22e. SIGNATURE Arthur S. Frank		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-4-60			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) (State) Arlington Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Hanlon Funeral Home, 3831 Georgia Ave., N.W., WDC			25a. REC'D BY REGISTRAR NOV 9 '60			25b. REGISTRAR'S SIGNATURE Arthur S. Frank					

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1231

STATE OF DEATH

1231

Dec. 1, 1941
U.S. Navy Hospital
100 Washington St., N.Y.
J. Edgar Hoover
100 Washington St., N.Y.
100 Washington St., N.Y.
100 Washington St., N.Y.

CHARLES W. O'DONOR

CHARLES W. O'DONOR

(1) CHARLES W. O'DONOR, born in N.Y.

born

CHARLES W. O'DONOR, born in N.Y.

CHARLES W. O'DONOR

Nov. 1, 1941

Nov. 1, 1941

11-1-41

U.S. Navy Hospital, 100 Washington St., N.Y.

11-1-41

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U.S. Navy Hospital, 100 Washington St., N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM AND Hospital</u>				d. STREET ADDRESS <u>2412 EVANS Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russell Douglas MILNER</u>				4. DATE OF DEATH Month Day Year <u>11 6 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-1903</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Thomas Cape San Trovch Agency</u>			
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>CLARENCE O. MILNER</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA Jensen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-42-1361</u>			
17. INFORMANT <u>WASHINGTON SANITARIUM Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct involving left anterior descending coronary artery</u> 420.1 DUE TO (b) <u>Massive myocardial fibrosis involving left antero-lateral myocardium</u> Since 1952 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary Thrombosis (old) 1952</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis (old) 1952</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1952</u> to <u>Nov 6, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 5 1960</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Nov 6 1960</u>							
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u> 22d. ADDRESS <u>10620 Angela Way Silver Spring Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/9/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>			

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
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12777

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1yr 8mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Olivia</u> Middle <u>P.</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Perrie</u>		14. MOTHER'S MAIDEN NAME <u>Helen Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas W. Pyle-son in law-same 2d</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis generalized</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>11-1-1960</u> , that (I) (we) last saw the deceased alive on <u>10-29-1960</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred S. Norton</u>		22b. DATE SIGNED <u>11/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>		22d. ADDRESS <u>4711 Highland Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 '60</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12778

12726

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS 4001 Weller Road,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Monkiewicz		4. DATE OF DEATH Month Day Year November 13, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, '60
9. AGE (In years last birthday) yrs. 15		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 15 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chester John Monkiewicz		14. MOTHER'S MAIDEN NAME Jean Marie Smink	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT mother		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA - APNEA DUE TO 16 HOURS Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) SHOULDER PRESENTATION (TWIN) DUE TO 16 HOURS (c) IN UTERO, PLACENTAL SEPARATION		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 13, 1960 , to NOV. 13, 1960 , that I last saw the deceased alive on NOV. 13, 1960 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L. Krichmar		ADDRESS (Street, city or town, state) 7733 ALASKA AVE NW	
PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR M.D.		DATE SIGNED NOV 16 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-14-60	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Washington San & Hosp.		24a. REC'D BY REGISTRAR NOV 17 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hare			

VS A15 (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 12
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12832
CERTIFICATE OF DEATH

12779

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>2325 42nd Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Maude</u> Last <u>Morey</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28 1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>50</u> Days <u>5</u> Hours <u>11</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milliner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert John Willoughby</u>		14. MOTHER'S MAIDEN NAME <u>Fanny M. Statton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>389-18-2484</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Staphylococcal Mediastinitis and Pericarditis</u> DUE TO (c) <u>Status Post-Operative ASD Repair</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>Days</u> <u>11 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atrial Septal Defect Post- Operative</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 19, 1960</u> , to <u>November 19, 1960</u> , that I last saw the deceased alive on <u>November 19, 1960</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. Brockenbrough, M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/19/60</u>	
PHYSICIAN'S NAME (Type) <u>E. C. Brockenbrough M.D.</u>		National Institutes of Health <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>11/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beechwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ottawa, Canada</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.,</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

CERTIFICATE OF DEATH

18812

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

12833

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12780

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>West Va</i> b. COUNTY <i>85X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charles Town</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	d. STREET ADDRESS <i>Box 410 - R.F.D. #1</i>	
3. NAME OF DECEASED (Type or print) First <i>Frances</i> Middle <i>Moulton</i> Last <i>Moulton</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/14/79</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lemon Parker Rawlings</i>		14. MOTHER'S MAIDEN NAME <i>Julia Monnier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>5123 Bradley Blvd. Beth, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i> DUE TO <i>446X</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>arteriosclerotic nephrosclerosis</i> DUE TO (c) <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the pancreas with liver metastases</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 30, 1960</i> to <i>Nov. 20, 1960</i> , that (I) (we) last saw the deceased alive on <i>Nov 20 1960</i> , and that death occurred at <i>7:15 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Senich T. Kimble</i>		22b. DATE SIGNED <i>11/20/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Senich T. Kimble</i>		22d. ADDRESS <i>929 Pershing Dr., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/23/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Edgehill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Charles Town, W. Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		25a. REC'D BY REGISTRAR <i>NOV 23 '60</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12781

12834

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 1533 Massachusetts Ave., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Frances Last MURRAY				4. DATE OF DEATH Month November Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-91	
				9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
						IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William BELL				14. MOTHER'S MAIDEN NAME Alice BARRICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-12-2505		17. INFORMANT (H) Wm. R. Murray, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) 4 days				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 15 4:45 AM to Nov. 18 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 18 , 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE R. Muth				22b. DATE 11-18-60			
22c. PHYSICIAN'S NAME (Type) R. MUTH, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-22-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517 11th Street, S.E., WashDC		25a. REC'D BY REGISTRAR NOV 22 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

12835

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12835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12782

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 14 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X -3 d. STREET ADDRESS 1524 F Street, N.E. - Apt. 105 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Lee Last MUSE				4. DATE OF DEATH Month November Day 22 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-05	
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55		11. IF UNDER 24 HRS. Hours 55		12. IF UNDER 24 HRS. Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John BROOKS				14. MOTHER'S MAIDEN NAME Estelle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT (S) Morris E. Christian, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic & hypertensive heart disease DUE TO (c) heart disease							INTERVAL BETWEEN ONSET AND DEATH 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Nov. 21, 1960 to Nov. 22, 1960 , that (X) (we) last saw the deceased alive on Nov. 22, 1960 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
22a. SIGNATURE R. G. Muth				22b. DATE SIGNED 11-22-60		22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Md. D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE J.T. Rhines				25a. REG. BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 12836 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville				c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg----Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Wesley Nichols				4. DATE OF DEATH Month Nov Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3-1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Self employed				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Lee Andrew F. Nichols				14. MOTHER'S MAIDEN NAME Margaret Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Mrs Gladys Nicholson, Poolesville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Rt hemiplegia 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive - Atherosclerotic Cardiovascular Disease DUE TO (c) 3 years INTERVAL BETWEEN ONSET AND DEATH 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 27 Oct. , 1960, to 6 Nov. , 1960, that I lost the deceased on 5 November , 1960, and that death occurred at 7 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 6 Nov 60			
PHYSICIAN'S NAME (Type) Gordon M. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8. 1960		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Hyattstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Willie B. Hallen, Barnesville, Md				24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Charles E. ...	

STATEMENT OF DEBIT

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

12837

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12784

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Silver Spring		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 704 McNeill Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Alice Middle Mae Last Niple		4. DATE OF DEATH Month 11 Day 17 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/83 7/3/81	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Levi Gill		14. MOTHER'S MAIDEN NAME Augusta Wilson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		
17. INFORMANT Elsie Burton (daughter) same as above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Coronary Decompensation DUE TO (b) Arteriosclerosis DUE TO (c) lyng cause lost. CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Pneumonia				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1956 to 17 Nov. 19 60 that (I) (we) last saw the deceased alive on 17 Nov. 19 60 and that death occurred at 3:55 PM , from the causes and on the date stated above.				
22a. SIGNATURE William D. Aud		22b. DATE SIGNED 11/17/60		
22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD		22d. ADDRESS 9006 Colesville Rd., Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/21/60		
23c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR NOV 23 '60		
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline		

CERTIFICATE OF DEATH

1923

14

1

Charles C. Thompson

1923

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12838 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12785

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 2700 Wisconsin Avenue, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle R Last North				4. DATE OF DEATH Month Nov. Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/19/74	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 11 Days 28 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gov't Employee				10b. KIND OF BUSINESS OR INDUSTRY Claims Dept.		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stitt				14. MOTHER'S MAIDEN NAME Maria Hanger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Address Chevy Chase, M d. Mrs. George Horning, Jr. 5325 Kenwood Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 3 wks. DUE TO Supraventricular infarction 5 wks. (b) Coronary atherosclerotic heart disease ? DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11/9 19 60 to 11/17/60 19 60 , that (I) (we) last saw the deceased alive on 11/16 19 60 and that death occurred on 11/17 AM, from the causes and on the date stated above.							
22a. SIGNATURE Bernard U. Walsh M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/17/60	
22c. PHYSICIAN'S NAME (Type) Bernard U. Walsh				22d. ADDRESS 1800 Eye St. N.W.-D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/19/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 21 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

12839

CERTIFICATE OF DEATH

12786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean H.</u> Middle <u>Oden</u> Last <u></u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/32</u>
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kirby Smith</u>		14. MOTHER'S MAIDEN NAME <u>Audrey Getz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Porter F Oden-Item# 2</u>	
17. ADDRESS <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL METASTASES</u> DUE TO <u>CARCINOMA OF BREAST</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>	
INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u> <u>5 MOS.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT. 1, 1960</u> to <u>NOV. 19, 1960</u> , that I last saw the deceased alive on <u>NOV. 19, 1960</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Tuohy</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7720 WISC. AVE, BETHESDA, MD. 11/19/60</u>	
PHYSICIAN'S NAME (Type) <u>John H. Tuohy</u>		<u>7720 Wis. Ave., Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>StLukes Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Redland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montgomery Ave.</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12727

CERTIFICATE OF DEATH

12787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 Silver Spring</i>	
f. STREET ADDRESS <i>1404 Torrington Place</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Oehl</i>		4. DATE OF DEATH Month Day Year <i>November 5 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-5-60</i>
9. AGE (In years last birthday) yrs. <i>10</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i>30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard A. Oehl</i>		14. MOTHER'S MAIDEN NAME <i>Geraldine Lee Kushon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>father</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyaline Membrane Disease of Lungs</i> <i>773.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>10 1/2 hours</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5 November 1960</i> , to <i>19</i> , that I last saw the deceased alive on <i>5 November 1960</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Russell B. Arnold</i> M.D.		ADDRESS (Street, city or town, state) <i>8801 Coleville Road, Silver Spring, Md.</i> DATE SIGNED <i>11/5/60</i>	
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>11-6-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium & Hospital, Takoma Park, Md.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hale, M.D., Washington</i>		ADDRESS <i>2075 301 XU 4 San & Hospital</i>	
24a. REC'D BY REGISTRAR <i>NOV 8 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12840

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12788

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY McArthur c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McArthur d. STREET ADDRESS 72X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Vance OGAN		4. DATE OF DEATH Month November Day 1 Year 19 60					
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-13-83	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 76	11. IF UNDER 24 HRS. Hours 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph D. OGAN			14. MOTHER'S MAIDEN NAME Nancy Jane HUGGINS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1901-1939		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 3 YEARS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROSIS, GENERALIZED							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oct. 19 19 59 to Nov. 1 19 60			
20f. (City or town) McArthur		(County) Ohio		(State) Ohio			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 19 19 59 to Nov. 1 19 60 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Nov. 1 19 60 , and that death occurred at 4 A. M. from the causes and on the date stated above.							
22a. SIGNATURE W. L. DeBolt		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-1-60			
22c. PHYSICIAN'S NAME (Type) W. L. DEBOLT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 11-2-60		23c. NAME OF CEMETERY OR CREMATORY Elk Cemetery			
23d. LOCATION (City, town, or county) McArthur		(State) Ohio					
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons		ADDRESS 1756 Penn. Ave., N.W., Wash DC		25a. REC'D BY REGISTRAR NOV 3 '60			
25b. REGISTRAR'S SIGNATURE Arthur E. Kraus							

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12841

CERTIFICATE OF DEATH

Reg. Dist. No.

12789

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA (WASHINGTON DC)</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM</u>				d. STREET ADDRESS <u>4845 LOUGHBORO RD. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DEPUE</u> Last <u>OGDEN</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13, 1867</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DAVID A. DEPUE</u>				14. MOTHER'S MAIDEN NAME <u>DELIA ANN SLOCUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>GEN. DAVID OGDEN</u> Address <u>4845 LOUGHBORO RD. NW</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> <u>420.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 y 10 -</u> <u>10 y 10 -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>58</u> , to <u>Nov. 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>60</u> , and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sm. R. Huffman</u> M.D. <u>1912 - R. H. West Jr.</u> PHYSICIAN'S NAME (Type) <u>George R. Huffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7 Nov. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>NEWARK NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINARD FUNERAL HOME INC</u> ADDRESS <u>816 HSB NE RD 2</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935-06-15"]		PLACE OF MARRIAGE [Faint text, possibly "St. Mary's Church"]		NAME OF SPouse [Faint text, possibly "Jane Doe"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		DATE OF DEATH [Faint text, possibly "1955-03-10"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]		NAME OF REGISTRAR [Faint text, possibly "John Doe"]		NAME OF WITNESS [Faint text, possibly "Jane Doe"]		NAME OF WITNESS [Faint text, possibly "John Doe"]		NAME OF WITNESS [Faint text, possibly "Jane Doe"]	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12842

12790

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>074 Suburban Hospital</u>		d. STREET ADDRESS <u>13114 Dumbarton Dr. Rockville Md</u>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Iris</u> Last <u>Oliver</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/55</u>
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Lola Hinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation trachea</u> <u>SIX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Erosion tracheotomy tube</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, cerebral palsy, microcephaly, epilepsy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> <u>1957</u> to <u>Nov</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> <u>1960</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard Auld</u>		22b. DATE SIGNED <u>11/18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Auld</u>		22d. ADDRESS <u>800 views Hill Rd. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24b. ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>NOV 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Caroline S. Kraus</u>	

1573

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1924

Name of deceased John J. Sullivan
 Date of death April 15, 1924
 Place of death at home
 Cause of death Heart Disease
 Age 45
 Sex Male
 Marital status Married
 Occupation Engineer
 Usual residence 123 Main St., Boston, Mass.
 Signature of physician [Signature]
 Date of certificate April 16, 1924
 Registrar's name [Signature]
 Date of registration April 16, 1924
 Registrar's office Bureau of Vital Records, Boston

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12843

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12791

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 74 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Calverton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ray Middle Albert Last O'ROARK		4. DATE OF DEATH Month November Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-01
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Daniel O'ROARK		14. MOTHER'S MAIDEN NAME Margaret Jane STIDHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI & II		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of lung DUE TO (c) 6 mo.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from August 22 19 60 to Nov. 4 19 60 , that (I) was last saw the deceased alive on Nov. 3 19 60 , and that death occurred at 6:05 AM , from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker		22b. DATE SIGNED 11-4-60	
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home		25a. REC'D BY REGISTRAR Nov 7 '60	
ADDRESS 2847 Wilson Blvd., Arlington, Va.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

12843

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

DECEASED (NAME)

U. S. Naval Hospital

DATE OF BIRTH

PLACE OF BIRTH

SEX

DECEASED

DATE

DECEASED

U. S. NAVY

DECEASED

INTERVIEWED JAMES WILLIAMS

DECEASED DANIEL O'BRIEN

U. S. Naval Hospital

DATE

U. S. NAVY

DATE

[Handwritten signature and text, mostly illegible]

U. S. NAVY
NOV 3 1918

U. S. NAVY
NOV 3 1918

U. S. NAVY
NOV 3 1918

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12844

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12792

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac (Rural)		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home		d. STREET ADDRESS 4214 Thornapple Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E Last O'TOOLE		4. DATE OF DEATH Month November Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1891
9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 1 Days 14	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney-retired		10b. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Patrick O'Toole		14. MOTHER'S MAIDEN NAME Ellen Riarden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-10-6479	
17. INFORMANT Katherine H. O'Toole-wife-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33ix Circulatory failure DUE TO (b) Cerebrovascular Accident and Pneumonia DUE TO (c) Cerebroarteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 4 hrs 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Nov 28, 1960 , that (I) (we) last saw the deceased alive on Nov 28, 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE W H Killay M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11/29/60	
22c. PHYSICIAN'S NAME (Type) W H Killay		22d. ADDRESS 10222 Falls Rd Rockville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR DEC 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1938

1938

CERTIFICATE OF

MONITORING

Colony (Rural)

Active Breeding House

JOSEPH

Wife

Active Breeding House

Active Breeding House

1938

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

Active Breeding House

12728

12793

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>304 Southwest Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>(NIMN)</u> Last <u>Overby</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-75</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Louise Snodgrass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>same as above</u> <u>Son - Mr. Archer R. Overby - above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral vascular accident</u> 331X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>August 1960</u> to <u>Nov. 9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov. 9</u> 19 <u>60</u> , and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				22b. DATE SIGNED <u>Nov. 9, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>				22d. ADDRESS <u>9301 Glesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VICKSBURG - Miss.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARVEY FUNERAL HOME - 3831 GA RD.</u>				25a. REC'D BY REGISTRAR <u>NOV 16 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
12845
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>5017 Loughboro Rd. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HUBERT E</u> Middle <u>M</u> Last <u>Page</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13 1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>	11. BIRTHPLACE (State or foreign country) <u>White Water, Wisconsin</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Page, Joseph Hubert</u>	
14. MOTHER'S MAIDEN NAME <u>Page, Esterly Era</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Esterly C. Page (Son)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic H.D. & age degeneration</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced arteriosclerosis generalized</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Four to five</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>many - Fall & fractured shoulder - renal failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall & fractured shoulder (minor contrib factor only)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 25, 1960</u> , to <u>Nov 9, 1960</u> , that I last saw the deceased alive on <u>Nov 6, 1960</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T Sullivan M.D.</u>		ADDRESS (Street, city or town, state) <u>1800 - Eye St NW Wash D.C.</u>	
DATE SIGNED <u>11/9/60</u>		DATE SIGNED <u>11/9/60</u>	
PHYSICIAN'S NAME (Type) <u>Richard T Sullivan M.D.</u>		ADDRESS <u>1800 - Eye St. N.W.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>11-10-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WHITE WATER, WISC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaurin Sons, Inc.</u>		ADDRESS <u>1756 - P Ave. N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12749 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12795

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>10 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>		d. STREET ADDRESS <u>4303 Brookfield Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4303 Brookfield Dr</u>				d. STREET ADDRESS <u>4303 Brookfield Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alex John Papanicolas</u>				4. DATE OF DEATH <u>Nov 9 1960</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-8-1923</u>		9. AGE (In years last birthday) <u>37</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Papanicolas</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Zonou</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>Yes Unknown</u>		17. INFORMANT <u>Marie Papanicolas (wife)</u> Address <u>Stim 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u>							
DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-9-60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 14 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

DATE

15740 MEDICAL EXAMINER CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death", "Date of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

Robert A. Thompson, Bethesda, Maryland
Hospital, 151st St., Arlington, Virginia
1914

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

12846

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12796

CERTIFICATE OF DEATH

Item 17 Film 276 12-16-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 147 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY North Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington d. STREET ADDRESS 4121 33rd Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle Lassiter Last PARISEAU		4. DATE OF DEATH Month November Day 24 Year 19 60				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-18	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 41	IF UNDER 24 HRS. Days 41 Hours 41 Min. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert R. LASSITER		14. MOTHER'S MAIDEN NAME Dearborn TREVETT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. (H) CDR Jos A. Pariseau, USN, same as #2 above		17. INFORMANT (H) CDR Jos A. Pariseau, USN, same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 170X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 1, 1960 to Nov. 24, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 24, 1960 , and that death occurred at 9:15 PM , from the causes and on the date stated above.						
22a. SIGNATURE D. L. Kelley		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 11-25-60		
22c. PHYSICIAN'S NAME (Type) D. L. KELLEY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va		25a. REC'D BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

CERTIFICATE OF DEATH

15880

OF DEATH

(1)

DATE OF DEATH

(1) The death of the deceased occurred on the

at the residence of the deceased

CERTIFICATE

Attest: _____
Registrar General, Virginia

Two copies of this certificate shall be filed in the office of the Registrar General, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12847

CERTIFICATE OF DEATH

Reg. Dist. No.

12797

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEABROOK MD 16042</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14511 Colesville Rd</u>		d. STREET ADDRESS <u>9900 SANTA GRUZ. ST</u>	
3. NAME OF DECEASED (Type or print) First <u>LORING</u> Middle <u>F.</u> Last <u>PAUL</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 29, 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICIAN</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT F. PAUL</u>		14. MOTHER'S MAIDEN NAME <u>EMMA TROUBAT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-0289A</u>	
17. INFORMANT <u>MYRTLE B. PAUL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Longstanding arteriosclerosis</u> (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1960</u> , to <u>Dec 14, 1960</u> , that I last saw the deceased alive on <u>Dec 14, 1960</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1917 Lemmy Rd. 11-17-60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN S. ROGERS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 17, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Altavilla</u> ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 16 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	

12848 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

12798 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Ada</u> Last <u>Peters</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 6, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Collier</u>		14. MOTHER'S MAIDEN NAME <u>Martha Berry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT (Nephew) <u>Lawrence L. Collier</u>		Address <u>805 Wade Ave., Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Right hemiplegia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>April 1953</u> to <u>Nov 13, 1960</u> that I last saw the deceased alive on <u>Nov 13, 1960</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Fawcett</u>		ADDRESS (Street, city or town, state) <u>M. Darnestown</u> DATE SIGNED <u>Nov 13, 1960</u>	
PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u>		<u>P. O. Bayard, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12849

CERTIFICATE OF DEATH

Reg. Dist. No.

12799

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rockville		c. LENGTH OF STAY IN lb 3 weeks 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Sanitarium		d. STREET ADDRESS 23 Cassilis Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katherine Middle R. Last Peugnet		4. DATE OF DEATH Month 11 Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1870
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 90 Days 14 Hours 19 Min. 60	11. IF UNDER 24 HRS. Months 90 Days 14 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York City, N. Y.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George B. Robinson		14. MOTHER'S MAIDEN NAME Lilla Bryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Louis P. Allyine 11411 Rockville Pike	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Bilateral Bronchopneumonia, Terminal DUE TO (b) Cerebral Thrombosis DUE TO (c) Generalized & Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 week 4 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 23, 1960 to Nov 14, 1960 that I last saw the deceased alive on Nov 13, 1960 and that death occurred at 2:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Horace H. Custis Jr		ADDRESS (Street, city or town, state) 1852 Columbia Rd NW WASH 9 D.C.	
PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR		DATE SIGNED NOV 15 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-15-1960	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) New York, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bawlers Sons, Inc. 1756 Pa. Ave. NW		24a. REC'D BY REGISTRAR NOV 15 '60	
24b. REGISTRAR'S SIGNATURE Christina L. Thomas			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1871

3. week 2 day

1

08

14

11

00

John P. C. [illegible]
[illegible]

Nov 14 60

Nov 13 60

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

12692

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12800

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		4-7X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2009 GRACE CHURCH ROAD		d. STREET ADDRESS 645 G St., S. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle GOLDIE Last PFEIFFER		4. DATE OF DEATH Month NOV. Day 18 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. THOMPSON		14. MOTHER'S MAIDEN NAME MARY JANE MULLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Louise P. McKenna, 2009 Grace Church Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Coronary Occlusion DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) 8 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 min 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/30/1954 to 11/18/1960 , that (I) (we) last saw the deceased alive on 10/31/1960 , and that death occurred at 8:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Russell B. Arnold M.D.		22b. DATE SIGNED 11/18/60	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d. ADDRESS 8801 Coleville Road, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/22/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		25a. REC'D BY REGISTRAR NOV 23 1960	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur J. Harris	

1893
CERTIFICATE OF DEATH

1

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
DATE OF DEATH
PLACE OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF MINISTER OF THE GOSPEL
SIGNATURE OF REGISTRAR

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

12850

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12801

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia P.G. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital Bethesda Md	
d. STREET ADDRESS 5036 Neptune Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Imogene Frances Middle Phelps Last		4. DATE OF DEATH Month November Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-25
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months 35 Days 11 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Illinoise	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Doan		14. MOTHER'S MAIDEN NAME Edna Courson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT Louis R. Phelps (h)		5036 Neptune Ave Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE (Mitral Insufficiency) AND (c) HEPATITIS, SERUM		INTERVAL BETWEEN ONSET AND DEATH 48 Hours 8 Years 2 Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-2-60 to 11-11-60 , that (I) (we) last saw the deceased alive on 11-11-60 , and that death occurred at 545 AM from the causes and on the date stated above.			
22a. SIGNATURE James M. Young		22b. DATE SIGNED 11-11-60	
22c. PHYSICIAN'S NAME (Type) James M. Young LT (MC) USN		22d. ADDRESS U.S. NAVAL HOSPITAL BETHESDA MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 11-13-60	
23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION (City, town, or county) (State) Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR NOV 13 60	
25b. REGISTRAR'S SIGNATURE William S. Harris		25c. ADDRESS Bethesda, Md.	

STATE OF NEW YORK

1892

Office of the State Comptroller

Albany

January 1st

Washington, D. C.

1892

Secretary of the Navy

U. S. Navy Department, Washington, D. C.

Department of the Navy

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Department of the Navy

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Albany

Albany

U. S. Navy Department

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U. S. Navy Department, Washington, D. C.

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U. S. Navy Department

U. S. Navy Department, Washington, D. C.

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U. S. Navy Department

U. S. Navy Department, Washington, D. C.

Albany

Albany

U. S. Navy Department

U. S. Navy Department

1892

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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12851

12802

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bethesda			
c. LENGTH OF STAY IN 1b 3 days				d. STREET ADDRESS 8130 Old Georgetown Rd.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter Quinn				4. DATE OF DEATH Month November Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 21, 1883	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Quinn				14. MOTHER'S MAIDEN NAME Ellen Holmes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 189205679		17. INFORMANT John F. Quinn, son		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Emphysema - Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/16/1953 to 11/28/1960 , that (I) (we) lost the deceased alive on 11/28/1960 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W. T. Joyce				22b. DATE SIGNED 11/28/60		22c. PHYSICIAN'S NAME (Type) W. T. JOYCE	
22d. ADDRESS 8106 Maple Ridge Rd., Bethesda, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 11-28-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Rose's Cemetery		23d. LOCATION (City, town, or county) (State) Carbondale, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR DATE NOV 29 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

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CERTIFICATE OF DEATH

15821



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12740
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12804

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION # 17 MAGNOLIA PARKWAY		d. STREET ADDRESS # 17 MAGNOLIA PARKWAY	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle W. Last RICHARDS		4. DATE OF DEATH Month November Day 28 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. GEOLOGIST		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) MAINE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT RICHARDS		14. MOTHER'S MAIDEN NAME LYDIA McINTIRE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT MRS. MARIE DeB. RICHARDS,		Address SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Coronary Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1940 to November 28, 1960 that (I) (we) last saw the deceased alive on 11-28-1960 , and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE Michael J. McInerney, M.D.		22b. DATE SIGNED 11-28-1960	
22c. PHYSICIAN'S NAME MICHAEL J. MCINERNEY, MD.		22d. ADDRESS 1150 - CONN. AVENUE, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/1/60	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Scullis Inc		ADDRESS 1756 PA. AVE., N.W.	
25a. REC'D BY REGISTRAR DATE DEC 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

1874

NO. 1000

DATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12805

12852

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Dunedin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 2233 Baywood Drive, West e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Warren Richards				4. DATE OF DEATH Month November Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1897		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY (Unknown)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Richards				14. MOTHER'S MAIDEN NAME Marian Webbe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None		17. INFORMANT The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Rheumatic Heart Disease, Inactive with calcific Aortic Stenosis, thickened insufficient Mitral Valve, thickened tricuspid valve, cardiac hypertrophy Atherosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 410X DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Hour						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.	Month 11 Day 21 Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from November 13, 1960 , to November 21, 1960 , that I last saw the deceased alive on November 21, 1960 , and that death occurred at 2:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11-21-60 DATE SIGNED							
ACTUAL SIGNATURE Benson R. Wilcox M.D.		M.D. The Clinical Center, Bethesda 14, Md. National Institutes of Health					
PHYSICIAN'S NAME (Type) BENSON R. WILCOX, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR NOV 23 1960	24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death

1. Name of Deceased		2. Sex		3. Age	
4. Date of Birth		5. Place of Birth		6. Usual Residence	
7. Cause of Death		8. Date of Death		9. Place of Death	
10. Signature of Physician		11. Signature of Registrar		12. Signature of Informant	
13. Name of Informant		14. Address of Informant		15. Telephone Number	
16. Name of Burial Place		17. Address of Burial Place		18. Name of Undertaker	
19. Name of Funeral Home		20. Address of Funeral Home		21. Name of Cemetery	
22. Name of Minister		23. Address of Minister		24. Name of Pastor	
25. Name of Rector		26. Address of Rector		27. Name of Priest	
28. Name of Chaplain		29. Address of Chaplain		30. Name of Rabbi	
31. Name of Imam		32. Address of Imam		33. Name of Minister	
34. Name of Pastor		35. Address of Pastor		36. Name of Rector	
37. Name of Priest		38. Address of Priest		39. Name of Chaplain	
40. Name of Rabbi		41. Address of Rabbi		42. Name of Imam	
43. Name of Minister		44. Address of Minister		45. Name of Pastor	
46. Name of Rector		47. Address of Rector		48. Name of Priest	
49. Name of Chaplain		50. Address of Chaplain		51. Name of Rabbi	
52. Name of Imam		53. Address of Imam		54. Name of Minister	
55. Name of Pastor		56. Address of Pastor		57. Name of Rector	
58. Name of Priest		59. Address of Priest		60. Name of Chaplain	
61. Name of Rabbi		62. Address of Rabbi		63. Name of Imam	
64. Name of Minister		65. Address of Minister		66. Name of Pastor	
67. Name of Rector		68. Address of Rector		69. Name of Priest	
70. Name of Chaplain		71. Address of Chaplain		72. Name of Rabbi	
73. Name of Imam		74. Address of Imam		75. Name of Minister	
76. Name of Pastor		77. Address of Pastor		78. Name of Rector	
79. Name of Priest		80. Address of Priest		81. Name of Chaplain	
82. Name of Rabbi		83. Address of Rabbi		84. Name of Imam	
85. Name of Minister		86. Address of Minister		87. Name of Pastor	
88. Name of Rector		89. Address of Rector		90. Name of Priest	
91. Name of Chaplain		92. Address of Chaplain		93. Name of Rabbi	
94. Name of Imam		95. Address of Imam		96. Name of Minister	
97. Name of Pastor		98. Address of Pastor		99. Name of Rector	
100. Name of Priest		101. Address of Priest		102. Name of Chaplain	
103. Name of Rabbi		104. Address of Rabbi		105. Name of Imam	
106. Name of Minister		107. Address of Minister		108. Name of Pastor	
109. Name of Rector		110. Address of Rector		111. Name of Priest	
112. Name of Chaplain		113. Address of Chaplain		114. Name of Rabbi	
115. Name of Imam		116. Address of Imam		117. Name of Minister	
118. Name of Pastor		119. Address of Pastor		120. Name of Rector	
121. Name of Priest		122. Address of Priest		123. Name of Chaplain	
124. Name of Rabbi		125. Address of Rabbi		126. Name of Imam	
127. Name of Minister		128. Address of Minister		129. Name of Pastor	
130. Name of Rector		131. Address of Rector		132. Name of Priest	
133. Name of Chaplain		134. Address of Chaplain		135. Name of Rabbi	
136. Name of Imam		137. Address of Imam		138. Name of Minister	
139. Name of Pastor		140. Address of Pastor		141. Name of Rector	
142. Name of Priest		143. Address of Priest		144. Name of Chaplain	
145. Name of Rabbi		146. Address of Rabbi		147. Name of Imam	
148. Name of Minister		149. Address of Minister		150. Name of Pastor	
151. Name of Rector		152. Address of Rector		153. Name of Priest	
154. Name of Chaplain		155. Address of Chaplain		156. Name of Rabbi	
157. Name of Imam		158. Address of Imam		159. Name of Minister	
160. Name of Pastor		161. Address of Pastor		162. Name of Rector	
163. Name of Priest		164. Address of Priest		165. Name of Chaplain	
166. Name of Rabbi		167. Address of Rabbi		168. Name of Imam	
169. Name of Minister		170. Address of Minister		171. Name of Pastor	
172. Name of Rector		173. Address of Rector		174. Name of Priest	
175. Name of Chaplain		176. Address of Chaplain		177. Name of Rabbi	
178. Name of Imam		179. Address of Imam		180. Name of Minister	
181. Name of Pastor		182. Address of Pastor		183. Name of Rector	
184. Name of Priest		185. Address of Priest		186. Name of Chaplain	
187. Name of Rabbi		188. Address of Rabbi		189. Name of Imam	
190. Name of Minister		191. Address of Minister		192. Name of Pastor	
193. Name of Rector		194. Address of Rector		195. Name of Priest	
196. Name of Chaplain		197. Address of Chaplain		198. Name of Rabbi	
199. Name of Imam		200. Address of Imam		201. Name of Minister	
202. Name of Pastor		203. Address of Pastor		204. Name of Rector	
205. Name of Priest		206. Address of Priest		207. Name of Chaplain	
208. Name of Rabbi		209. Address of Rabbi		210. Name of Imam	
211. Name of Minister		212. Address of Minister		213. Name of Pastor	
214. Name of Rector		215. Address of Rector		216. Name of Priest	
217. Name of Chaplain		218. Address of Chaplain		219. Name of Rabbi	
220. Name of Imam		221. Address of Imam		222. Name of Minister	
223. Name of Pastor		224. Address of Pastor		225. Name of Rector	
226. Name of Priest		227. Address of Priest		228. Name of Chaplain	
229. Name of Rabbi		230. Address of Rabbi		231. Name of Imam	
232. Name of Minister		233. Address of Minister		234. Name of Pastor	
235. Name of Rector		236. Address of Rector		237. Name of Priest	
238. Name of Chaplain		239. Address of Chaplain		240. Name of Rabbi	
241. Name of Imam		242. Address of Imam		243. Name of Minister	
244. Name of Pastor		245. Address of Pastor		246. Name of Rector	
247. Name of Priest		248. Address of Priest		249. Name of Chaplain	
250. Name of Rabbi		251. Address of Rabbi		252. Name of Imam	
253. Name of Minister		254. Address of Minister		255. Name of Pastor	
256. Name of Rector		257. Address of Rector		258. Name of Priest	
259. Name of Chaplain		260. Address of Chaplain		261. Name of Rabbi	
262. Name of Imam		263. Address of Imam		264. Name of Minister	
265. Name of Pastor		266. Address of Pastor		267. Name of Rector	
268. Name of Priest		269. Address of Priest		270. Name of Chaplain	
271. Name of Rabbi		272. Address of Rabbi		273. Name of Imam	
274. Name of Minister		275. Address of Minister		276. Name of Pastor	
277. Name of Rector		278. Address of Rector		279. Name of Priest	
280. Name of Chaplain		281. Address of Chaplain		282. Name of Rabbi	
283. Name of Imam		284. Address of Imam		285. Name of Minister	
286. Name of Pastor		287. Address of Pastor		288. Name of Rector	
289. Name of Priest		290. Address of Priest		291. Name of Chaplain	
292. Name of Rabbi		293. Address of Rabbi		294. Name of Imam	
295. Name of Minister		296. Address of Minister		297. Name of Pastor	
298. Name of Rector		299. Address of Rector		300. Name of Priest	
301. Name of Chaplain		302. Address of Chaplain		303. Name of Rabbi	
304. Name of Imam		305. Address of Imam		306. Name of Minister	
307. Name of Pastor		308. Address of Pastor		309. Name of Rector	
310. Name of Priest		311. Address of Priest		312. Name of Chaplain	
313. Name of Rabbi		314. Address of Rabbi		315. Name of Imam	
316. Name of Minister		317. Address of Minister		318. Name of Pastor	
319. Name of Rector		320. Address of Rector		321. Name of Priest	
322. Name of Chaplain		323. Address of Chaplain		324. Name of Rabbi	
325. Name of Imam		326. Address of Imam		327. Name of Minister	
328. Name of Pastor		329. Address of Pastor		330. Name of Rector	
331. Name of Priest		332. Address of Priest		333. Name of Chaplain	
334. Name of Rabbi		335. Address of Rabbi		336. Name of Imam	
337. Name of Minister		338. Address of Minister		339. Name of Pastor	
340. Name of Rector		341. Address of Rector		342. Name of Priest	
343. Name of Chaplain		344. Address of Chaplain		345. Name of Rabbi	
346. Name of Imam		347. Address of Imam		348. Name of Minister	
349. Name of Pastor		350. Address of Pastor		351. Name of Rector	
352. Name of Priest		353. Address of Priest		354. Name of Chaplain	
355. Name of Rabbi		356. Address of Rabbi		357. Name of Imam	
358. Name of Minister		359. Address of Minister		360. Name of Pastor	
361. Name of Rector		362. Address of Rector		363. Name of Priest	
364. Name of Chaplain		365. Address of Chaplain		366. Name of Rabbi	
367. Name of Imam		368. Address of Imam		369. Name of Minister	
370. Name of Pastor		371. Address of Pastor		372. Name of Rector	
373. Name of Priest		374. Address of Priest		375. Name of Chaplain	
376. Name of Rabbi		377. Address of Rabbi		378. Name of Imam	
379. Name of Minister		380. Address of Minister		381. Name of Pastor	
382. Name of Rector		383. Address of Rector		384. Name of Priest	
385. Name of Chaplain		386. Address of Chaplain		387. Name of Rabbi	
388. Name of Imam		389. Address of Imam		390. Name of Minister	
391. Name of Pastor		392. Address of Pastor		393. Name of Rector	
394. Name of Priest		395. Address of Priest		396. Name of Chaplain	
397. Name of Rabbi		398. Address of Rabbi		399. Name of Imam	
400. Name of Minister		401. Address of Minister		402. Name of Pastor	
403. Name of Rector		404. Address of Rector		405. Name of Priest	
406. Name of Chaplain		407. Address of Chaplain		408. Name of Rabbi	
409. Name of Imam		410. Address of Imam		411. Name of Minister	
412. Name of Pastor		413. Address of Pastor		414. Name of Rector	
415. Name of Priest		416. Address of Priest		417. Name of Chaplain	
418. Name of Rabbi		419. Address of Rabbi		420. Name of Imam	
421. Name of Minister		422. Address of Minister		423. Name of Pastor	
424. Name of Rector		425. Address of Rector		426. Name of Priest	
427. Name of Chaplain		428. Address of Chaplain		429. Name of Rabbi	
430. Name of Imam		431. Address of Imam		432. Name of Minister	
433. Name of Pastor		434. Address of Pastor		435. Name of Rector	
436. Name of Priest		437. Address of Priest		438. Name of Chaplain	
439. Name of Rabbi		440. Address of Rabbi		441. Name of Imam	
442. Name of Minister		443. Address of Minister		444. Name of Pastor	
445. Name of Rector		446. Address of Rector		447. Name of Priest	
448. Name of Chaplain		449. Address of Chaplain		450. Name of Rabbi	
451. Name of Imam		452. Address of Imam		453. Name of Minister	
454. Name of Pastor		455. Address of Pastor		456. Name of Rector	
457. Name of Priest		458. Address of Priest		459. Name of Chaplain	
460. Name of Rabbi		461. Address of Rabbi		462. Name of Imam	
463. Name of Minister		464. Address of Minister		465. Name of Pastor	
466. Name of Rector		467. Address of Rector		468. Name of Priest	
469. Name of Chaplain		470. Address of Chaplain		471. Name of Rabbi	
472. Name of Imam		473. Address of Imam		474. Name of Minister	
475. Name of Pastor		476. Address of Pastor		477. Name of Rector	
478. Name of Priest		479. Address of Priest		480. Name of Chaplain	
481. Name of Rabbi		482. Address of Rabbi		483. Name of Imam	
484. Name of Minister		485. Address of Minister		486. Name of Pastor	
487. Name of Rector		488. Address of Rector		489. Name of Priest	
490. Name of Chaplain		491. Address of Chaplain		492. Name of Rabbi	
493. Name of Imam		494. Address of Imam		495. Name of Minister	
496. Name of Pastor		497. Address of Pastor		498. Name of Rector	
499. Name of Priest		500. Address of Priest		501. Name of Chaplain	
502. Name of Rabbi		503. Address of Rabbi		504. Name of Imam	
505. Name of Minister		506. Address of Minister		507. Name of Pastor	
508. Name of Rector		509. Address of Rector		510. Name of Priest	
511. Name of Chaplain		512. Address of Chaplain		513. Name of Rabbi	
514. Name of Imam		515. Address of Imam		516. Name of Minister	
517. Name of Pastor		518. Address of Pastor		519. Name of Rector	
520. Name of Priest		521. Address of Priest		522. Name of Chaplain	
523. Name of Rabbi		524. Address of Rabbi		525. Name of Imam	
526. Name of Minister		527. Address of Minister		528. Name of Pastor	
529. Name of Rector		530. Address of Rector		531. Name of Priest	
532. Name of Chaplain		533. Address of Chaplain		534. Name of Rabbi	
535. Name of Imam		536. Address of Imam		537. Name of Minister	
538. Name of Pastor		539. Address of Pastor		540. Name of Rector	
541. Name of Priest		542. Address of Priest		543. Name of Chaplain	
544. Name of Rabbi		545. Address of Rabbi		546. Name of Imam	
547. Name of Minister		548. Address of Minister		549. Name of Pastor	
550. Name of Rector		551. Address of Rector		552. Name of Priest	
553. Name of Chaplain		554. Address of Chaplain		555. Name of Rabbi	
556. Name of Imam		557. Address of Imam		558. Name of Minister	
559. Name of Pastor		560. Address of Pastor		561. Name of Rector	
562. Name of Priest		563. Address of Priest		564. Name of Chaplain	
565. Name of Rabbi		566. Address of Rabbi		567. Name of Imam	
568. Name of Minister		569. Address of Minister		570. Name of Pastor	
571. Name of Rector		572. Address of Rector		573. Name of Priest	
574. Name of Chaplain		575. Address of Chaplain		576. Name of Rabbi	
577. Name of Imam		578. Address of Imam		579. Name of Minister	
580. Name of Pastor		581. Address of Pastor		582. Name of Rector	
583. Name of Priest		584. Address of Priest		585. Name of Chaplain	
586. Name of Rabbi		587. Address of Rabbi		588. Name of Imam	
589. Name of Minister		590. Address of Minister		591. Name of Pastor	
592. Name of Rector		593. Address of Rector		594. Name of Priest	
595. Name of Chaplain		596. Address of Chaplain		597. Name of Rabbi	
598. Name of Imam		599. Address of Imam		600. Name of Minister	
601. Name of Pastor		602. Address of Pastor		603. Name of Rector	
604. Name of Priest		605. Address of Priest		606. Name of Chaplain	
607. Name of Rabbi		608. Address of Rabbi		609. Name of Imam	
610. Name of Minister		611. Address of Minister		612. Name of Pastor	
613. Name of Rector		614. Address of Rector		615. Name of Priest	
616. Name of Chaplain		617. Address of Chaplain		618. Name of Rabbi	
619. Name of Imam		620. Address of Imam		621. Name of Minister	
622. Name of Pastor		623. Address of Pastor		624. Name of Rector	
625. Name of Priest		626. Address of Priest		627. Name of Chaplain	
628. Name of Rabbi		629. Address of Rabbi		630. Name of Imam	
631. Name of Minister		632. Address of Minister		633. Name of Pastor	
634. Name of Rector		635. Address of Rector		636. Name of Priest	
637. Name of Chaplain		638. Address of Chaplain		639. Name of Rabbi	
640. Name of Imam		641. Address of Imam		642. Name of Minister	
643. Name of Pastor		644. Address of Pastor		645. Name of Rector	
646. Name of Priest		647. Address of Priest		648. Name of Chaplain	
649. Name of Rabbi		650. Address of Rabbi		651. Name of Imam	
652. Name of Minister		653. Address of Minister		654. Name of Pastor	
655. Name of Rector		656. Address of Rector		657. Name of Priest	
658. Name of Chaplain		659. Address of Chaplain		660. Name of Rabbi	
661. Name of Imam		662. Address of Imam		663. Name of Minister	
664. Name of Pastor		665. Address of Pastor		666. Name of Rector	
667. Name of Priest		668. Address of Priest		669. Name of Chaplain	
670. Name of Rabbi		671. Address of Rabbi		672. Name of Imam	
673. Name of Minister		674. Address of Minister		675. Name of Pastor	
676. Name of Rector		677. Address of Rector		678. Name of Priest	
679. Name of Chaplain		680. Address of Chaplain		681. Name of Rabbi	
682. Name of Imam		683. Address of Imam		684. Name of Minister	
685. Name of Pastor		686. Address of Pastor		687. Name of Rector	
688. Name of Priest		689. Address of Priest		690. Name of Chaplain	
691. Name of Rabbi		692. Address of Rabbi		693. Name of Imam	
694. Name of Minister		695. Address of Minister		696. Name of Pastor	
697. Name of Rector		698. Address of Rector		699. Name of Priest	
700. Name of Chaplain		701. Address of Chaplain		702. Name of Rabbi	
703. Name of Imam		704. Address of Imam		705. Name of Minister	
706. Name of Pastor		707. Address of Pastor		708. Name of Rector	
709. Name of Priest		710. Address of Priest		711. Name of Chaplain	
712. Name of Rabbi		713. Address of Rabbi		714. Name of Imam	
715. Name of Minister		716. Address of Minister		717. Name of Pastor	
718. Name of Rector		719. Address of Rector		720. Name of Priest	
721. Name of Chaplain		722. Address of Chaplain		723. Name of Rabbi	
724. Name of Imam		725. Address of Imam		726. Name of Minister	
727. Name of Pastor		728. Address of Pastor		729. Name of Rector	
730. Name of Priest		731. Address of Priest		732. Name of Chaplain	
733. Name of Rabbi		734. Address of Rabbi		735. Name of Imam	
736. Name of Minister		737. Address of Minister		738. Name of Pastor	
739. Name of Rector		740. Address of Rector		741. Name of Priest	
742. Name of Chaplain		743. Address of Chap			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 1/2 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 6601 Goldsboro Ct.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jessie		First Ray		Middle Robinson		Last Robinson		4. DATE OF DEATH Nov. 19, 1960		Month 19	
5. SEX female		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/18		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY South Carolina		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Henry Ray		14. MOTHER'S MAIDEN NAME Arelia Metts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sister. Mrs. Frances Davies		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RUPTURE, LENTICULOSTRIATE ARTERIES, RIGHT DUE TO (c) HYPERTENSIVE CARDIOVASCULARRENAL DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours UNKNOWN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on floor at home & struck head against cabinet		20c. TIME OF INJURY Month, Day, Year 11/19/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		M.D. Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/20/60	
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) BURIAL		22b. DATE THEREOF 11-23-1960		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) 4611 Benning Rd., S.E. Wash., D.C.		24a. REC'D BY REGISTRAR DATE NOV 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	
23. FUNERAL DIRECTOR'S SIGNATURE MALVAN & SCHEY, INC.		ADDRESS 424 "R" St., N. W.		Wash., D.C.		24a. REC'D BY REGISTRAR DATE NOV 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12854

12806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>16724-Wilson Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>B.</u> Last <u>Rosenberger</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/08</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horticulturist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l Cathedral Pennsylvania</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Rosenberger</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Kenworthy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>166-87-9315</u>		17. INFORMANT Address <u>Same as Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT BRONCHIO PNEUMONIA</u> DUE TO (b) <u>NEOPLASTIC BLOOD DISEASE, UNDETERMINED</u> DUE TO (c) <u>TYPE</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> to <u>Nov 23</u> 19 <u>60</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov 23</u> 19 <u>60</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>DeWitt E. DeLawter</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/23/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWITT E. DeLawter</u>				22d. ADDRESS <u>8025 Aberdeen Rd. Bethesda, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1882

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death", and "Date" are faintly visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12855

CERTIFICATE OF DEATH

Reg. Dist. No.

12807

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown	
f. STREET ADDRESS 1 R.F.D. #2		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle G. Last Ross		4. DATE OF DEATH Month 11 Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1898
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Arthur Gable		14. MOTHER'S MAIDEN NAME Florence Brindel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-40-9388	
INFORMANT Hugh Ross(husband)		Address same as above	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural effusion DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma of lungs + pleura DUE TO 3 weeks (c) carcinoma (adenoma) of the breast DUE TO 2 years 6 months		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1205 PM		20f. (City or town) (County) (State) DAWSONVILLE	
21. I certify that I attended the deceased from June 32 nov 1960 , 19 60 , to Nov 22 1960 , that I lost saw the deceased alive on Nov 22 1960 , and that death occurred at 12:05 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DAWSONVILLE	
ACTUAL SIGNATURE John G. Fawcett		DATE SIGNED 11/22/60	
PHYSICIAN'S NAME (Type) John G. Fawcett		P.O. Box 4, D. MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR NOV 28 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

12872

CERTIFICATE OF DEATH

STATE OF MARYLAND

NOTARY PUBLIC

John S. Hancock

Robert A. Humphrey, Bethesda, Maryland

John S. Hancock

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12856

12808

12856

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>2 yr 1 mo</u>				d. STREET ADDRESS <u>5211 Norwood Ave</u>			
d. NAME OF HOSPITAL (If not an hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kathryn F. Rupperecht</u>				4. DATE OF DEATH <u>Nov 16 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 26, 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Ford</u>				14. MOTHER'S MAIDEN NAME <u>Roseann Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Madaline Robison</u> Address <u>Baltimore MD 3520 Locken Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>471X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cachexia</u> DUE TO <u>Psychotic Depression</u> (c) <u>1 mo</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 wks</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-7-1959</u> to <u>11-16-1960</u> that (I) (we) last saw the deceased alive on <u>11-15-1960</u> and that death occurred on <u>11-16-1960</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Roy B. Parsons MD</u>				22b. DATE SIGNED <u>11-16-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Roy B. Parsons Tr MD</u>				22d. ADDRESS <u>Burtonville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tuckner</u> ADDRESS <u>Beltz 17, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE <u>NOV 21 1960</u>			

(M)

(I)

(O)

(1)

(BP)

1

DATE OF BIRTH: 10/10/1910 PLACE OF BIRTH: NEW YORK CITY

NAME: JOHN J. SMITH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Montgomery Co. Deputy Medical Examiner notified and released to hospital.

12857

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12810

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, NMMC, BETHESDA, MARYLAND				d. STREET ADDRESS 4603 OVERBROOK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella First May Middle ST. CLAIR Last		4. DATE OF DEATH Month 11 Day 24 Year 1960					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-80	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N.A.		11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Joyner				14. MOTHER'S MAIDEN NAME Margaret E. Love			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Address Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (Probable Cerebral Thrombosis) DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH less than 1 hr 9 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis in 1951 April 1960.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-24 1960 to 11-24 1960, that (I) (we) last saw the deceased alive on 11-24 1960, and that death occurred at 1:30AM from the causes and on the date stated above.							
22a. SIGNATURE John W. Davis		22b. DATE SIGNED 11-24-60		22c. PHYSICIAN'S NAME (Type) J. W. DAVIS LT MC USN			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 11-24-60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Tutelo, Miss.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY, FUNERAL HOME 7557 Wisc. Ave. BETHESDA, Md.				25a. REC'D BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

1887

JOHN J. ... (Name of Deceased)
... (Address of Deceased)
... (City and State of Deceased)

... (Date of Death)
... (Time of Death)
... (Cause of Death)

... (Signature of Physician)
... (Signature of Registrar)

... (Signature of Deceased)

... (Signature of Witnesses)

... (Signature of Deceased)

... (Signature of Deceased)

... (Signature of Deceased)

... (Signature of Deceased)

... (Signature of Deceased)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12729

12729

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12809

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eva</u> Last <u>Salb</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. - 1 - 1897</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>03</u> Days <u>03</u> Hours <u>03</u> Min. <u>03</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Biggs</u>		14. MOTHER'S MAIDEN NAME <u>ADDIE E. LENNOX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO <u>Essential hypertension</u> (c) <u>Aplastic anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u> <u>15 yrs.</u> <u>25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aplastic anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>60</u> to <u>11-2</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel M. Bazeant</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Washington, D.C.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-30-60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u>		25a. REC'D BY REGISTRAR <u>3831 Ga An. NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25c. DATE NOV 29 '60	

CERTIFICATE OF DEATH

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12858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12811

Reg. Dist. No.

Items 4, 8, 9, 17 Filed 12-5-60 at

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY CANADA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toronto 5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5104 Viking Road		d. STREET ADDRESS 50 St. Andrew's Gardens	
3. NAME OF DECEASED (Type or print) First Cicely Middle Noel Last SAVAGE		4. DATE OF DEATH Month November Day 17 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 Dec. 25, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Month 10 Day 27	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? Canadian	
13. FATHER'S NAME George William Henry French		14. MOTHER'S MAIDEN NAME Emily Garland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Mrs. Rodger Anderson		Address ; Same as Item #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-60	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery
		22d. LOCATION (City, town, or county) (State) Mongtomgery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERTA A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE NOV 21 '60		24b. REGISTRAR'S SIGNATURE Curtis R. K...	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12750

CERTIFICATE OF DEATH

Reg. Dist. No.

12812

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10231 Carroll Place Carroll Hall Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3416 Rittenhouse Street, N.W. e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First ELLEN B. Middle SCHERMERHORN Last		4. DATE OF DEATH Month November Day 17 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1859
9. AGE (In years lost birthday) 101 yrs.		10. BIRTHPLACE (State or foreign country) New Jersey	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Bell		14. MOTHER'S MAIDEN NAME Katherine Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR Disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 422.1 DUE TO (c) 422.1		INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 16, 1960 , to November 17, 1960 , that I last saw the deceased alive on Nov 16, 1960 , and that death occurred at 9:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE De Witt E. De Lawter		ADDRESS (Street, city or town, state) 8025 ABERDEEN Rd. Bethesda 14, Md.	
PHYSICIAN'S NAME (Type) DEWITT E. DELAWTER, M.D.		DATE SIGNED 11-17-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR 2901 11th St., N.W. Washington, D.C.	
24b. REGISTRAR'S SIGNATURE Nov 21 '60		24c. REGISTRAR'S SIGNATURE Carroll L. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Pages 1 and 2 should be filed with
Then please remove carbon papers

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14593

CERTIFICATE OF DEATH

14596

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 4 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAVAREST NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Maria Elizabeth Last Schlenker				4. DATE OF DEATH Month 11 / Day 17 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/66		9. AGE (In years lost birthday) 94 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRIEDRICH WILHELM KRUMM				14. MOTHER'S MAIDEN NAME CATHARINA MARIE CHRISTINE PLATTHOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Miss Anna A. Schlenker, 6629 23rd Pl. W. Hyattsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1949 to Nov , 1960 that (I) (we) last saw the deceased alive on Nov 8 , 1960, and that death occurred at 11:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Maurice Franks				22b. DATE SIGNED 11/18/60		22c. PHYSICIAN'S NAME (Type) Maurice Franks, M.D.	
22d. ADDRESS 901 20th NW, Wash D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 11/21/60		23c. NAME OF CEMETERY OR CREMATORY MT. WALLASTON CEMETERY		23d. LOCATION (City, town, or county) (State) QUINCY, MASS.	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. PUMPHREY, INC. Raymond G. Zicka				25a. REC'D BY REGISTRAR APR 4 '61		25b. REGISTRAR'S SIGNATURE Charles E. Jones	

page 3 should be detached for use by the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

14593

STATE OF DEATH

DEATH CERTIFICATE OF DEATH

14593

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12730

CERTIFICATE OF DEATH

12813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> p. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Cedar Haven Ave</i> <i>7300 Balt</i>		d. STREET ADDRESS <i>1704 Gilbert St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>OLIVIA</i> Last <i>Senyohl</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec 5, 1899</i> 80 yrs.
9. AGE (In years last birthday) <i>80</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMEMAKER</i>	
11. BIRTHPLACE (State or foreign country) <i>DULUTH, MINN.</i>		12. CITIZEN OF WHAT COUNTRY? <i>YES USA</i>	
13. FATHER'S NAME <i>THEODORE SENYOHL</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH PETERSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>476-05-7375</i>	
17. INFORMANT <i>HOWARD C. CHISHOLM</i>		Address <i>704 GILBERT ST TAKOMA PARK 12, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO <i>Arteriosclerosis</i> (c) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>a. 11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 7</i> , 1960, to <i>Nov 28</i> , 1960, that I last saw the deceased alive on <i>Nov 8</i> , 1960, and that death occurred at <i>6:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>11/28/60</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Philip C. Jones</i> M.D.		918 Ellsworth Drive	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>11/30/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WERNER E. FURNESS, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>DEC 2 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12731
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12814

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>--</i> b. COUNTY <i>--</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>13 1/2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 47X-</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>				d. STREET ADDRESS <i>3602 South Dakota Ave N.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edith</i> First <i>Amelia</i> Middle <i>SHAHER</i> Last		4. DATE OF DEATH Month <i>11</i> Day <i>3</i> Year <i>1960</i>					
5. SEX <i>female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-18-78</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Buhler</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Horner.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Wash. San & Hosp Records.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASHD C congestive failure</i> (c) <i>6 months</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1960</i> to <i>11/3</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>11/3</i> 19 <i>60</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/3/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>Hugh W. Irey</i>		22d. ADDRESS <i>7105 Riggs Road, Hyattsville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>11/7/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Ft. Myer, Va.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>2701 14th NW</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 7 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

MEDICAL CERTIFICATION

STATE OF NEW YORK

1874

1874

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

12859

12815

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 96 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Dade c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Opa-Locka d. STREET ADDRESS 2821 NW 154th Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harold Cleaves SHAW				4. DATE OF DEATH Month Day Year November 18 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-86	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles SHAW				14. MOTHER'S MAIDEN NAME Alma PRESTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & WWII		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Branchogenic carcinoma with DUE TO central metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) central metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 6 months				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 14 1960 to Nov. 18 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 18 1960 , and that death occurred at 11:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. M. Young, LTMC, USN				22b. DATE SIGNED 11-19-60		22c. PHYSICIAN'S NAME (Type) J. M. Young, LTMC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11-21-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. REC'D BY REGISTRAR DATE NOV 28 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

AP

CERTIFICATE OF DEATH

1873

1. Name of deceased
2. Age
3. Sex
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of registrar
9. Date of registration

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12860

CERTIFICATE OF DEATH

Reg. Dist. No.

12816

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Damascus				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Germantown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ollie Middle M. Last Shaw				4. DATE OF DEATH Month Nov. Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1878	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Colesville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edward Shaw				14. MOTHER'S MAIDEN NAME Mary V. Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Yes ?			
INFORMANT Mrs Elsie R. Shaw, Gaithersburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 5 , 1960, to Nov. 30 , 1960, that I last saw the deceased alive on Nov. 29 , 1960, and that death occurred at 8:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 195 Russell Ave., Gaithersburg, Md. DATE SIGNED 12-2-60 ACTUAL SIGNATURE Jack Schomacher M.D. PHYSICIAN'S NAME (Type) Jack Schomacher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Derwood		22d. LOCATION (City, town, or county) (State) Derwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobern				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE DEC 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12732

12817

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 34 YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 LINCOLN AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 310 LINCOLN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERMAN Middle OTTO Last SIKORRA		4. DATE OF DEATH Month NOVEMBER Day 30 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 24, 1889 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR		10b. KIND OF BUSINESS OR INDUSTRY BANK	
11. BIRTHPLACE (State or foreign country) CAVOUR SOUTH DAKOTA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST SIKORRA		14. MOTHER'S MAIDEN NAME AUGUSTA KOSCHESKI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 574-05-2034	
17. INFORMANT EMILY M. SIKORRA		Address 310 LINCOLN AVE. TAKOMA PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery sclerosis DUE TO 1 yr (c) Generalized cardio-vascular dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1960 to Nov 1960 that (I) (we) last saw the deceased alive on 30 Nov 1960 and that death occurred at 6:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Ernest E. Shannon M.D.		22b. DATE SIGNED 11/30/60	
22c. PHYSICIAN'S NAME (Type) ERNEST E. SHANNON M.D.		22d. ADDRESS 9301 Columbia Rd. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DECEMBER 3, 1960	
23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON		23d. LOCATION (City, town, or county) (State) ADELPHI, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		25a. REC'D BY REGISTRAR DEC 2 '60	
ADDRESS 254 CARROLL ST. N.W. - WASH. D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

15715

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12818

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 14 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,818 Flack Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIETTA Middle SINOPOLI Last SINOPOLI		4. DATE OF DEATH Month NOV. Day 4 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/81
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 4 Days 5 Hours 1 Min.	11. IF UNDER 24 HRS. Months 4 Days 5 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEANORDO SINOPOLI		14. MOTHER'S MAIDEN NAME ROSA COLOSIMO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 082-01-0830-A	
17. INFORMANT Mr. Jack Sinopoli, 12,818 Flack St.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) 4-5 years INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 19 57 , to NOV 4 , 19 60 , that (I) we last saw the deceased alive on NOV 4 , 19 60 , and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Morris Perry		22b. DATE SIGNED NOV 4, 1960	
22c. PHYSICIAN'S NAME (Type) MORRIS PERRY		22d. ADDRESS 11602 Ga. Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/60	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPUREY, INC. Raymond A. Ziska		25a. REC'D BY REGISTRAR NOV 9 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Howard			

17

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

15893

Blank form with faint horizontal lines for text entry.

Vertical text on the right margin, possibly a date or file number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12694

CERTIFICATE OF DEATH

12819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>3 yrs</i>		d. STREET ADDRESS <i>702 Lanark Way</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>702 LANARK WAY</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Hilliard Snoutfer</i>		4. DATE OF DEATH <i>Nov. 10 1960</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 13, 1866</i>	
9. AGE (In years last birthday) <i>94</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (RETIRED)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN FARM</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>George Fenton Snoutfer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hebb</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mrs R. Talbot</i>		Address <i>Danvers Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Emboli</i> <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Cardiac Failure</i> DUE TO (c) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>years</i> <i>6 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 4</i> , 19 <i>60</i> , to <i>Nov. 10</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Nov. 10</i> , 19 <i>60</i> , and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i>		ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		DATE SIGNED <i>11/10/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/12/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WERNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>DATE NOV 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12751
CERTIFICATE OF DEATH

Reg. Dist. No.

12820

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb ?	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10231 Carroll Place Carroll Hall Sanitarium		d. STREET ADDRESS 1423 Madison Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hector Middle G. Last SPaulding		4. DATE OF DEATH Month Nov Day 6 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Professor of Law-		10b. KIND OF BUSINESS OR INDUSTRY G.W. University	
11. BIRTHPLACE (State or foreign country) Fargo North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Spaulding		14. MOTHER'S MAIDEN NAME Lucretia Galloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
INFORMANT John Spaulding		Address 4315 Chestnut Street Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO congestive heart failure and shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 10 days (b) hypertension and urinary retention (c) arteriosclerotic cardiovascular disease 2 years INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart; Pernicious anemia			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 20, 1959 , to Nov 5, 1960 that I last saw the deceased alive on Nov. 5, 1960 , and that death occurred at 5A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) WASHINGTON Clinic DATE SIGNED ACTUAL SIGNATURE Edward W. Youngblood M.D. PHYSICIAN'S NAME (Type) EDWARD W. YOUNGBLOOD WASHINGTON 15, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 11/9/1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
ADDRESS 2901 14th St N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

CERTIFICATE OF DEATH

12345

1. Name of Deceased: [Illegible]
2. Sex: [Illegible]
3. Age: [Illegible]
4. Date of Birth: [Illegible]
5. Date of Death: [Illegible]
6. Place of Death: [Illegible]
7. Cause of Death: [Illegible]
8. Signature of Physician: [Illegible]
9. Signature of Registrar: [Illegible]
10. Date of Registration: [Illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

12821

12861

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES L SPROUSE				4. DATE OF DEATH NOV. 20 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/87		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Coal miner)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John J. Sprouse				14. MOTHER'S MAIDEN NAME Mary Agnes Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 236-10-8410			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Intracerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture, aneurysm of Arteria Communicans, Arteria Unknown DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from NOV 18, 1960 , to NOV 20, 1960 , that I last saw the deceased alive on NOV 20, 1960 , and that death occurred at 2:05 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward A. Beeman M.D.				ADDRESS (Street, city or town, state) 10620 GEORGIA AVE. DATE SIGNED			
PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN				SILVER SPRING, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Colmar Manor Md.				24a. REC'D BY REGISTRAR NOV 28 '60			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO
DEPARTMENT OF HEALTH

1924

Dr. C. A. Smith, P. O. Box 111, Mt. Vernon, Ohio

Dr. C. A. Smith, P. O. Box 111, Mt. Vernon, Ohio

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12822

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8806 GLENVILLE ROAD				d. STREET ADDRESS 1 8806 GLENVILLE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle HOBAN Last STANFORD				4. DATE OF DEATH Month NOV. Day 25 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/19/96		9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK-BINDER		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. Gov't. Printing Office		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN STANFORD				14. MOTHER'S MAIDEN NAME ELLEN unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW # 1 195-10-5212		17. INFORMANT Address Mrs. Margaret I. Stanford, 8806 Glenville Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDIFFERENTIATED CARCINOMA Uterine Bladder DUE TO 181-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED METASTASES TO CALTLEXIA DUE TO 6MO-1YR. (c) TERMINAL EMACIATION AND DEBILITY DUE TO 6WKS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) "AS ABOVE" INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YRS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 56 to Nov. 25 19 60 , that (I) (we) last saw the deceased alive on Nov. 25 19 56 and that death occurred at 6:20 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Quinn MD.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS F. QUINN MD.				22d. ADDRESS 501-B Southhampton Drive Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/29/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Gishka				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE DEC 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

1888

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12823

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 904 HIGHLAND DR.		d. STREET ADDRESS 1904-HIGHLAND DR.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LIBBY Middle - Last STEINBERG		4. DATE OF DEATH Month NOV Day 15 Year 1960	
5. SEX F	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME REBECCA - (UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALFRED STEINBERG		Address 904 Highland Dr Silver Spring MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) 5 min. YEARS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC HEART DISEASE, HYPERTENSIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 13 yrs	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 27 1960 to NOV 15, 1960 , that (I) (we) last saw the deceased alive on 11/12 1960 , and that death occurred at 12:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Morton H Rose M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MORTON H ROSE		22d. ADDRESS 1801 EYE ST NW WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-18-1960	
23c. NAME OF CEMETERY OR CREMATORY NATL MEM. PARK		23d. LOCATION (City, town, or county) (State) FALLS CHA VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Geoffrey J. [unclear]		25a. REC'D BY REGISTRAR NOV 21 '60	
ADDRESS 4217-9th Ave		25b. REGISTRAR'S SIGNATURE Arthur S. [unclear]	

CERTIFICATE OF DEATH

15894

1

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12862 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12824											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 2 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington, D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 733 Otis Place, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frances Sterling						4. DATE OF DEATH 11/ 7 19 60					
5. SEX F		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/28/17		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Fortune						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Doratha Evans Address (Item #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) History of hypertension										INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 11/7/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/11/60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial.		22d. LOCATION (City, town, or country) (State) Suitland, Md.			
23. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md.						24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Washington, D.C.

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Washington

temporary general

733 Ohio Place, N.W.

James

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Virginia

U.S.A.

Albert Fortune

Albany

(Form #2)

Political Name

temporary occupation

Albany

History of hypertension

James W. Roosevelt

Washington, D.C.

11/21/17

12863

12825

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1880

CHURCH OF THE HOLY TRINITY, N.Y.

CHURCH OF THE HOLY TRINITY, N.Y.

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12826

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>R-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roland E Stull</u>				4. DATE OF DEATH <u>Nov 14 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/23</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>			
11. PLACE OF BIRTH (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clinton Eugene Stull</u>				14. MOTHER'S MAIDEN NAME <u>Rose Ann Howard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>220-30-0914</u>			
17. INFORMANT <u>Mrs. Dora Tasker, 2120 Westchester Ave. Catonsville 28 Md</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures Left Pelvis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>816X</u> DUE TO (b) <u>(Pneumonia, Ileum and Isquemia)</u>							
DUE TO (c) <u>Fracture base of skull (sphenoid bone)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>mv & mv</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:30 am 11-16 1960</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> el work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Ellicott City</u>				20g. (County) <u>Howard</u>		20h. (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>	
22d. LOCATION (City, town, or country) <u>Ellicott City, Md</u>				22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>NOV 21 '60</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12827

12697

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1825 Tilton Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES MAY SULLIVAN				4. DATE OF DEATH Month NOV. Day 13 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/28/86	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DANIEL DURNING				14. MOTHER'S MAIDEN NAME ANNIE FERGUSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. John J. Sullivan, 1825 Tilton Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1956 to Nov. 13, 1960 , that (I) (we) last saw the deceased alive on Nov. 13, 1960 , and that death occurred at 7:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Edward J. Richards				22b. DATE SIGNED 11-13-60			
22c. PHYSICIAN'S NAME (Type) EDWARD J. RICHARDS				22d. ADDRESS 10,110 Ga. Ave., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/16/60		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				25a. REC'D BY REGISTRAR DATE NOV 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12865

CERTIFICATE OF DEATH

12828

Item 1 FilmG277 12-2-60 et

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		c. LENGTH OF STAY IN lb <i>D.O.A.</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		d. STREET ADDRESS <i>5306 Kenwood Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Kenneth</i> Middle <i>T</i> Last <i>Sullivan</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>18</i> Year <i>1960</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>W.H.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1905</i>		9. AGE (In years last birthday) <i>55</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Raymond Drake</i> Address <i>5904 Ryland Dr. Bethesda, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>3 yrs.</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congestive heart failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 1957</i> to <i>Nov 18, 1960</i> that (I) (we) last saw the deceased alive on <i>May 18, 1960</i> , and that death occurred at <i>11:55 PM</i> from the causes and on the date stated above.	
22a. SIGNATURE <i>Willard R. Ermantraut</i>		22b. DATE SIGNED <i>11/18/60</i>		22c. PHYSICIAN'S NAME (Type) <i>Willard R. Ermantraut M.D.</i>		22d. ADDRESS <i>4890 Battery Lane, Bethesda, Md.</i>		22e. REC'D BY REGISTRAR <i>NOV 22 60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/22/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		25a. DATE <i>NOV 22 60</i>		25c. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

[Faint, illegible text, likely bleed-through from the reverse side of the page]

CERTIFICATE OF DEATH

Reg. Dist. No.

12829

12866

1. PLACE OF DEATH a. COUNTY Montg b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b Boys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg, Co. General Hosp, e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Earl Last Sutphin				4. DATE OF DEATH Month Nov Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26-1923	
9. AGE (In years lost birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 6 Days 24 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Vicker. Va.	
13. FATHER'S NAME Stanford E. Sutphin				14. MOTHER'S MAIDEN NAME Trophy Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 				16. SOCIAL SECURITY NO. 		INFORMANT Address Lois U. Sutphin. Boys. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Synovialoma, metd static 227X DUE TO retroperitoneal Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Primary, right foot DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Secondary to Part Ia.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1953 , 19____, to Nov. 20, 1960 , that I last saw the deceased alive on Nov. 20, 1960 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 Russell Ave., Gaithersburg, Md. DATE SIGNED 11-21-60							
ACTUAL SIGNATURE Jack Schumacher M.D.				PHYSICIAN'S NAME (Type) Jack Schumacher Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-60		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg, Md.				24a. REC'D BY REGISTRAR NOV 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12867 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN 1b <u>1/2 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Browningsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Haney Ave</u>				d. STREET ADDRESS <u>RFD # 1, Monrovia</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Edwin Tabler</u>				4. DATE OF DEATH Month Day Year <u>11 - 15 - 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1899</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - well driller</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Lewis Tabler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Vennie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219-12-0165</u>		17. INFORMANT Address <u>Mrs Fannie Tabler- Monrovia, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-15-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrman</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1

12807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12698

CERTIFICATE OF DEATH

Reg. Dist. No. 12831

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15		d. STREET ADDRESS Boeteler Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAVA REST NURSING HOME UNIV. Bldg.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Ovelton Last TALBOTT		4. DATE OF DEATH Month NOV. Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 May 6 1878
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County Worker		10b. KIND OF BUSINESS OR INDUSTRY County Govt.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Talbott		14. MOTHER'S MAIDEN NAME Susan Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE —	
17. INFORMANT Hazel Boeteler		Address Boeteler Rd, Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 5, 1960 to Nov. 20, 1960 , that I last saw the deceased alive on Nov. 18, 1960 , and that death occurred at 3:00 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Laubach M.D.		DATE SIGNED 1806 FOX ST, Hyattsville 11/20/60	
PHYSICIAN'S NAME (Type) JAMES L. LAUBACH		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/23/60	
22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12832

12699

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MDX D. C. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1800 Grace Church Road			d. STREET ADDRESS 3040 Oliver Street, F. W.		
3. NAME OF DECEASED (Type or print) JOHN Peter TALTY			4. DATE OF DEATH Nov. 18, 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1870		9. AGE (In years last birthday) 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur-retired			10b. KIND OF BUSINESS OR INDUSTRY Driving		11. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME John Talty			14. MOTHER'S MAIDEN NAME Mary Cushing		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Joseph Greco-son in law-same 2d			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebral Thromboses DUE TO Cerebral Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senescent Arterio-Sclerosis (c) Senescent Arterio-Sclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 months 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/10/1940 to 11/18/1960 , that (I) (we) last saw the deceased alive on 11/17/1960 , and that death occurred at 11/18/1960 M, from the causes and on the date stated above.					
22a. SIGNATURE E. Stuart Lyddane			22b. DATE SIGNED 11-18-60		
22c. PHYSICIAN'S NAME (Type) E. STUART LYDDANE			22d. ADDRESS 3066 Q St., N. W., Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town, or county) Washington, D. C.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			25a. REC'D BY REGISTRAR Bethesda, Maryland		
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			DATE NOV 22 '60		

CLINICAL OF DEATH

12883

W. D. C.

Montgomery

Washington

Silver Spring

1000 Grace Church Road

1000 91st Street, N.W.

Peter

John

Wife

Wife

2/1/87

2/1/87

2/1/87

Champion-Tested

Belmont

Belmont

John Taylor

Mary Gunning

John Taylor, son-in-law of

Belmont

Robert A. Humphrey, Bethesda, Maryland

W. D. C.

Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12833

12868

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5415 Harwood Road				d. STREET ADDRESS 5415 Harwood Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Carson Last TATUM				4. DATE OF DEATH Month November Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/26/1911	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months 7 Days 28 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent-Manufact.				10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Charles G. Tatum				14. MOTHER'S MAIDEN NAME Bess Carson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 289-07-6970		17. INFORMANT Francis Tatum, wife, same 2d Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate One year.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-14 19 60 , to 11-24 19 60 , that (I) (we) last saw the deceased alive on 11-18 19 60 , and that death occurred at 9:40 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert J. McCarthy				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-24-60	
22c. PHYSICIAN'S NAME (Type) Robert J. McCarthy				22d. ADDRESS 1801 EYE ST N.W. WASH, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR NOV 28 '60 DATE		25b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLINICAL OF PATH

12888

History

Physical

Examination

History

Physical

Examination

1801 EYE

1801 EYE

1801 EYE

1801 EYE

1801 EYE

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12757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13215 Midway Ave.</u>		d. STREET ADDRESS <u>13215 Midway Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>W.</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lindsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-2116</u>	
17. INFORMANT <u>Katherine M. Thompson-Item# 2</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal hemorrhage</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured peptic ulcer</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/2/58</u> , 19 <u> </u> , to <u>11/15/60</u> 19 <u> </u> , that I last saw the deceased alive on <u>11/15/60</u> , 19 <u> </u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Patrick C. Jameson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12020 Georgia Ave., Wheaton, Md.</u> <u>11/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>		<u>12020 Georgia Ave., Wheaton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1331 E. Montg. Ave., Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1929

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12869

12855

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>17509-Jackson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Killian</u> Middle <u>Mary</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/95</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
13. FATHER'S NAME <u>Warner W. L. Donger</u>		14. MOTHER'S MAIDEN NAME <u>Angie Crane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>54-09-3800 B</u>	
17. INFORMANT <u>George S. Thompson</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-vascular-renal disease</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>I</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>I</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>59</u> , to <u>Nov 22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov. 22</u> 19 <u>60</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip H. Varner</u>		22b. DATE SIGNED <u>11-23-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>		22d. ADDRESS <u>19620 He. Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>11/26/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT PEACE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PENNSYLVANIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Central", "Quart", and "1888" are faintly visible.]

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12700
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12836

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>11 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>May</i> Last <i>Thompson</i>				4. DATE OF DEATH Month <i>11</i> - Day <i>15</i> - Year <i>1960</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-7-82</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Crawford Phillips</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <i>Washington Sanitarium & Hospital Records</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombotic Infarction</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from <i>Nov 4, 1960</i> to <i>Nov 15, 1960</i> , that (I) (we) last saw the deceased alive on <i>11/15/60</i> , and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Boris Rabkin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN</i>				22d. ADDRESS <i>1019 University Blvd East</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 17, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Ph. Del. Co. Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Waller</i>				ADDRESS <i>254 Carroll St. NW. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 17 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>			

CERTIFICATE OF DEATH

15100

Blank certificate form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12870

CERTIFICATE OF DEATH

Reg. Dist. No.

12857

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 207 WILLIAMSBURG DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA First Middle Last TURKAL		4. DATE OF DEATH Month 11 Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/69
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. M. James Turkal, 207 Williamsburg Dr. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1-2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Amputation Rt. leg above knee 11/13/60		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 5 mo , 19 60 , that I last saw the deceased alive on 5 mo , 19 60 , and that death occurred at 4:5 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 906 Glenview Rd Silver Spring Md	
ACTUAL SIGNATURE William D. Aud M.D.		DATE SIGNED 11/5/60	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/8/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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1947

CERTIFICATE OF DEATH

RECEIVED BY THE DEPARTMENT OF HEALTH

1947

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DR. J. J. JONES, JR., 301 W. 11th Street, St. Paul, Minn.

DEPARTMENT OF HEALTH

Dr. J. J. JONES, JR., 301 W. 11th Street, St. Paul, Minn.

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Dr. J. J. JONES, JR., 301 W. 11th Street, St. Paul, Minn.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12838

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7801 GARLAND</u>		d. STREET ADDRESS <u>17801 GARLAND AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE ANN TURNER</u>		4. DATE OF DEATH Month Day Year <u>Nov 23 1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11 - 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>80</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM DALE QUANTRILLE</u>		14. MOTHER'S MAIDEN NAME <u>A. VICTORIA THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Shutdown with Uremia</u> <u>450.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Labia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>23 Nov</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>22 Nov</u> , 19 <u>60</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Queen</u> M.D.		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>23 Nov 1960</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN M.D.</u>		TAKOMA PARK, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 25, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PAVE EXTENDED PR GO. G. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll NW DC</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Hume</u>	
24c. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Date of registration: _____</p>	
<p>10. Remarks: _____</p>	

11. Name of informant: _____
 12. Address of informant: _____
 13. Signature of informant: _____
 14. Date of completion: _____
 15. Remarks: _____

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12871

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12839

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Co.</i> b. COUNTY <i>47X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>924 Southern Ave. S.E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>William James Twilley</i>		4. DATE OF DEATH Month Day Year <i>Nov. 21 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 10, 1886</i> 9. AGE (In years last birthday) <i>74</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Statler Hotel</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Twilley</i>		14. MOTHER'S MAIDEN NAME <i>Emma J. Forbes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-07-3954</i> 17. INFORMANT <i>Eva L. Twilley</i> Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Obstruction Superior Vena Cava.</i> DUE TO (c) <i>Benchogenic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>12 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> 19 to <i>November 21, 1960</i> , that (I) (we) last saw the deceased alive on <i>Nov. 21</i> 19 <i>60</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Jack Crawford</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JACK CROKELL</i>		22d. ADDRESS <i>2025 Eye St., N.W. Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov 25-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Switland, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros</i> ADDRESS <i>1661-gd Hope Rd & E West DC</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 28 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

STATEMENT OF DEATH

15871

(M)

(I)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12840

12734

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>36</u> d. STREET ADDRESS <u>11925 College View Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Michael Ullias</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1960</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 30 - '07</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cap. Nat'l. Parks Dept. of Interior</u>				11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>			
13. FATHER'S NAME <u>John Ullias</u>				14. MOTHER'S MAIDEN NAME <u>Dembiczak Sophia</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>207-05-0055</u>				17. INFORMANT <u>Hospital Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary polycythemia</u> DUE TO (c) <u>Mitriary granulomatous pulmonary disease, cause unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of liver</u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> 19 <u>60</u> , to <u>Nov 24</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 23</u> , 19 <u>60</u> , and that death occurred at <u>12:00</u> AM, from the causes and on the date stated above.															
22a. SIGNATURE <u>Sydney Leventhal</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>				22d. ADDRESS <u>9210 Colsoville Rd, Silver Spring Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thaus</u>					

1923

CERTIFICATE OF DEATH

1923

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. AISM
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12841											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7039 Strathmore st</u>				d. STREET ADDRESS <u>17039 Strathmore st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willard Bart Upright</u>		First Middle Last		4. DATE OF DEATH <u>Nov 8 1960</u>		Month Day Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		DATE OF BIRTH <u>12-18-04</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drafting</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Drafting</u>				11. BIRTHPLACE (State or foreign country) <u>Michigan</u>			
13. FATHER'S NAME <u>Willard S. Upright</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lambert</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WW 2 578-05-2908</u>				17. INFORMANT <u>Ruth E. Upright-wife-same 2d</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-8-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) <u>Suitland, Maryland</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

HEALTH TO THOSE WHO, FOR ANY REASON, ARE UNABLE TO OBTAIN THE SAME THROUGH THE REGULAR COURSE OF MEDICAL CARE.

68-07-00000

(continued)

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

1992-1993

1245

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Summary

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102

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
12873

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12843

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 3018 Aberdeen Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Helen Cuthpert VAN KEUREN				4. DATE OF DEATH Month Day Year November 27 19 60											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-82		9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert MOLLEN				14. MOTHER'S MAIDEN NAME Alice LALOR											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. - - - - -				17. INFORMANT (H) RADM Alexander Van Keuren, USN, Ret. Address same as #2 above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive cardiac failure 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative bleeding duodenal ulcer DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Virginia		(State) Virginia			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 23 19 60 to Nov. 27 19 60 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Nov. 27 19 60 , and that death occurred at 8:10AM M, from the causes and on the date stated above.															
22a. SIGNATURE Clifford M. Herman						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-27-60							
22c. PHYSICIAN'S NAME (Type) Clifford M. HERMAN, LT, MC, USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-1-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey Funeral Home						ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

CERTIFICATE OF DEATH

1284

NAME OF DECEASED: *Robert William* SEX: *Male* AGE: *30* DATE OF BIRTH: *Nov. 23, 1910*

PLACE OF BIRTH: *Philadelphia, Pa.* PLACE OF DEATH: *U. S. Naval Hospital, Bethesda, Md.*

DATE OF DEATH: *Nov. 27, 1940* TIME OF DEATH: *11:30 PM*

CAUSE OF DEATH: *Cholera* MEDICAL ATTENDANT: *Dr. J. H. H. H.*

DATE OF INTERMENT: *Nov. 28, 1940* PLACE OF INTERMENT: *U. S. Naval Hospital, Bethesda, Md.*

NAME OF FUNERAL HOME: *U. S. Naval Hospital, Bethesda, Md.*

SIGNATURE OF DECEASED: *Robert William*

SIGNATURE OF WITNESSES: *(H) JAMES ALEXANDER VAN KORMAN, USN, RET.*

Post-operative

Nov. 23 6:10 PM

Clifford M. H. H.

CLIFFORD M. H. H., LT, USN, U. S. Naval Hospital, Bethesda, Md.

12-1-40 Arlington National Cemetery, Arlington, Virginia

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12874

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12844

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>52 Chevy Chase, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>17501 Wyndale RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise - Veihmeyer</u>				4. DATE OF DEATH Month Day Year <u>Nov. 4 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4, 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pr. High Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>J. OLIVER VEIHMAYER</u>				14. MOTHER'S MAIDEN NAME <u>Nekkie Leavy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Helen Holmes - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio Renal Disease</u> DUE TO (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10/21 1960</u> to <u>11/4 1960</u> that (I) (we) last saw the deceased alive on <u>11/4 1960</u> and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Alvin I Kay</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alvin I Kay MD</u>				22d. ADDRESS <u>1835 Eye St NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-8-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>WASH. D.C. 3821 14th. ST. N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 275 11-29-60 ams 12875										MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 12845									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church (Rural) 3. STREET ADDRESS 351 Munson Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Virginia Middle Todd Last Venneman					4. DATE OF DEATH Month November Day 16 Year 19 60														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician				10b. KIND OF BUSINESS OR INDUSTRY U.S. (Unknown) Gov.				11. BIRTHPLACE (State or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Luther E. Todd					14. MOTHER'S MAIDEN NAME Lee Wheeler														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 519-05-8389		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Widespread Metastatic Carcinoma of Breast DUE TO (c) Status Post Hypophysectomy Hypophysectomy										INTERVAL BETWEEN ONSET AND DEATH 2 Months 7 Years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Status Post Hypophysectomy Hypophysectomy																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 8 November 19 60 to 16 November 19 60		(County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 16 November 19 60 to 16 November 19 60 that (I) (we) last saw the deceased alive on 16 November 19 60 and that death occurred at 7:30 AM from the causes and on the date stated above.																			
22a. SIGNATURE Leo Stolbach						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Leo L. Stolbach						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11-18-1960		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEMETERY				23d. LOCATION (City, town, or county) ARLINGTON, VA. (State)									
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler Sons, Inc.						ADDRESS 1756-Pa. Ave. N.W.		25a. REC'D BY REGISTRAR Nov 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1587

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12735

12846

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 34					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>				d. STREET ADDRESS <i>3913 Littleton St.</i> 1					
3. NAME OF DECEASED (Type or print) First <i>Letta</i> Middle <i>Melvina</i> Last <i>Walliker</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>4</i> Year <i>1960</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-21-79</i>			
9. AGE (In years lost birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>									
13. FATHER'S NAME <i>Knut Liguin</i>				14. MOTHER'S MAIDEN NAME <i>Eliza ? (unknown)</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Hospital Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis, generalized</i> DUE TO (c) <i>Anteriosclerotic heart disease</i>								INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anteriosclerotic heart disease</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> 19 <i>60</i> to <i>11/4</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>11/3</i> 19 <i>60</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Eino Magi</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/4/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>				22d. ADDRESS <i>918 Univ. Blvd. E. Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<i>Burial - transit</i>		<i>11-5-60</i>		<i>Springdale Cemetery</i>		<i>Clinton, Iowa</i>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>R. G. Humphrey - 7557 Wisconsin Rd. Bethesda, Md.</i>				25a. REC'D BY REGISTRAR <i>NOV 9 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

12847

12876

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 510 Walker Street, S.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Wampler		4. DATE OF DEATH Month November Day 8 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1919	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Federal Government		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Stephens				14. MOTHER'S MAIDEN NAME Ethel Bank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, due to Pseudomonas 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 3 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 19 60 , to November 8, 19 60 , that I last saw the deceased alive on November 8, 19 60 , and that death occurred at 10:15 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. Walter Oppelt</i> M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 11-9-60	
PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Linville Creek Church		22d. LOCATION (City, town, or county) (State) Broadway, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Money King</i> ADDRESS <i>Chen Davis</i> Vienna, Virginia				24a. REGISTRY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
12877
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12848

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>074 Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NATHANIEL</u> <u>WARREN</u>		4. DATE OF DEATH Month Day Year <u>NOV.</u> <u>29</u> <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/98</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FEED Comp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Warren</u>		14. MOTHER'S M maiden name <u>Melinda Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Charles Warren</u>	
17. INFORMANT <u>Brother Same as Above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ATHEROSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 28</u> 19 <u>60</u> , to <u>NOV 29</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>NOV 29</u> 19 <u>60</u> , and that death occurred at <u>3:54</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		22d. ADDRESS <u>10620 GEORGIA AVE. SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Saroden</u>		25a. REC'D BY REGISTRAR <u>DEC 1 '60</u> DATE	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1927

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

... of ...
... born ...
... died ...
... cause of death ...
... place of death ...
... signed ...
... Registrar ...
... Date ...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 (M)

12878

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12849

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 53 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle JOHNSON Last WASHINGTON				4. DATE OF DEATH Month NOVEMBER Day 19 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11- 41916	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 4 Hours 4 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			
13. FATHER'S NAME Unknown JOHNSON				14. MOTHER'S MAIDEN NAME ISABELL DORSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. HOSPITAL RECORDS, OLNEY, MARYLAND			
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 445X IMMEDIATE CAUSE (a) Malignant hypertension DUE TO arteriosclerotic nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Bilateral pulmonary edema (marked) DUE TO (b) Bilateral pulmonary edema (marked) (c) Bilateral pulmonary edema (marked) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11/19 19 60 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/17 19 60 , to 11/19 19 60 , that (I) (we) last saw the deceased alive on 11/19 19 60 , and that death occurred 11/19 19 60 from the causes and on the date stated above.							
22a. SIGNATURE G. F. MEADORS, MD				22b. DATE SIGNED 11/22/60			
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, MD				22d. ADDRESS DAMASCUS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/22/60			
23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery				23d. LOCATION (City, town, or county) (State) Boyd, Md			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR NOV 28 '60			
25b. REGISTRAR'S SIGNATURE Arthur J. Hume				25c. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12879
CERTIFICATE OF DEATH
12850

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 18 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 4851 Sedgewick St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Frances Work WEBB				4. DATE OF DEATH Month Day Year November 2 19 60											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-90		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry WORK						14. MOTHER'S MAIDEN NAME Mary JUDGE									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral arterial thromboses, multiple DUE TO (b) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 24 months												INTERVAL BETWEEN ONSET AND DEATH 24 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Nov. 2 1960		(County)		(State)			
21. I certify that the (this hospital) attended the deceased from April 13 1959 to Nov. 2 1960 , that he (we) last saw the deceased alive on Nov. 2 1960 , and that death occurred at 10:10PM , from the causes and on the date stated above.															
22a. SIGNATURE R. G. Muth				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-3-60					
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-7-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

SECTION 15 OF DEATH

15874

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12736

12851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Ind.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		d. STREET ADDRESS <u>3404 Purdue St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Nunn</u> Last <u>Webb</u>		4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-09</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer - Navy Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ua.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ua.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Guy Webb, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Helen Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>11-25-60</u>	
17. INFORMANT <u>wife, Fidler M. Webb</u>		Address <u>3404 Purdue St. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 <u>60</u> , to <u>Nov 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> 19 <u>60</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon L. Gallin M.D.</u>		22b. DATE SIGNED <u>11-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u>		22d. ADDRESS <u>7206 Colesville Rd., Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-29-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town, or county) (State) <u>Wheaton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>		25a. REC'D BY REGISTRAR <u>5801 Cleveland Ave</u>	
ADDRESS <u>Riverdale, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12850

12852

1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		c. LENGTH OF STAY IN 1b		5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Chevy Chase		55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Suburban		d. STREET ADDRESS		4629 Hunt Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Frances		W		White		November		18		19		60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White				11/23/38		71 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Herman		U.S.A				New York									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. Address					
Herman		Ella Cooke		No		Unknown		Benjamin White		18 Peacock Farms Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hypoxia</u> DUE TO <u>Respiratory Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Respiratory Arrest</u> DUE TO <u>Cardiac Failure</u> (c) <u>Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>2 hours</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast, Surgically Resected</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12:53 to Nov 18, 1960 that (I) (we) last saw the deceased alive on Nov 17, 1960 and that death occurred at 10:52 M, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE					
Stewart Clapp		11/18/60		Stewart Clapp		4740 Chevy Chase Dr.		Chevy Chase Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Cremation		11/19/1960		Cedar Hill		Prince George		Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE							
Robert A. Pumphrey		Bethesda, Maryland		NOV 22 '60		Arthur S. Thomas									

CERTIFICATE OF DEATH

1888

10 1888

10 1888

Unknown

Prince George, Maryland

October 11, 1888

Robert T. Murphy, Bethesda, Maryland

12853

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C.		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eventide Nursing Home				d. STREET ADDRESS 1753 Kilbourne Place N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORA		First LORA		Last WHITE		4. DATE OF DEATH Month Nov. Day 13 Year 19 60	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/76	
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months 83		IF UNDER 24 HRS. Days 83		Hours 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George White				14. MOTHER'S MAIDEN NAME Kathryn Lowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Washington, DC Edward White-1753 Kilbourne Pl. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Distention DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 5-10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/16/60 to Nov 13 , 19 60 , that (I) (we) last saw the deceased alive on Nov 13 , 19 60 , and that death occurred at 11/13/60 , from the causes and on the date stated above.							
22a. SIGNATURE W.B. Wardrop M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/13/60	
22c. PHYSICIAN'S NAME (Type) W.B. WARDROP M.D.				22d. ADDRESS 800 PERSHING DRIVE SILVER SPRING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/16/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				ADDRESS WASHINGTON, D. C.		25a. REC'D BY REGISTRAR NOV 15 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1901

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12881
CERTIFICATE OF DEATH

12854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barrett</u> Middle <u>U.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Herrmantown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachariah Williams</u>		14. MOTHER'S MAIDEN NAME <u>Vandelia R. Saper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-03-0505</u>	
17. INFORMANT <u>Ruth Williams</u> Address <u>5105 W. Franklin Rd. Richmond Va.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, posterior Septal.</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of Coronary Arteries</u> DUE TO (c) <u>Arteriosclerosis of Coronary Arteries</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 7, 1960</u> , to <u>Nov 12, 1960</u> , that I last saw the deceased alive on <u>Nov 12, 1960</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael R. Dobridge</u>		DATE SIGNED <u>Nov 12, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave. Silver Spring Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>NOV 15 '60</u>	
ADDRESS <u>2901-14th St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF ANALYSIS

1881

[Faint, mostly illegible text follows, likely containing analysis results and signatures.]



1943

CHURCH OF NORTH

1943



Heberle, Paul
Heberle, Paul

Heberle, Paul

Heberle, Paul

Heberle, Paul



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>12883</p> </div> <div> <p>STATE OF MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> </div> <div> <p>12856</p> </div> </div> <p style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</p>											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,				c. LENGTH OF STAY IN 1b 12 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital				d. STREET ADDRESS 102 Chevy Chase Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert E. Lee				First Middle Last Robert E. Lee Wiltberger				4. DATE OF DEATH Month Day Year Nov. 23 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1866		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist				10b. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Wash. Washington D. C		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JOHN WILTBERGER				14. MOTHER'S MAIDEN NAME MARY BORAH							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Wife Mrs. Virginia Wiltberger (same)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 5-10 mins	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 5 Nov. 23 1960			
21. I certify that (I) (this hospital) attended the deceased from 1960 to Nov. 23 1960 , that (I) (we) last saw the deceased alive on Nov. 23 1960 , and that death occurred at 9 PM , from the causes and on the date stated above.											
22a. SIGNATURE George A. Gray, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/23/60	
22c. PHYSICIAN'S NAME (Type) GEORGE A. GRAY, JR. M.D.				22d. ADDRESS 4440 Chevy Chase Dr. Ch. Ch. Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/26/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Hines	

THE UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Large block of illegible text, likely a memorandum or report body]

12752

CERTIFICATE OF DEATH

Reg. Dist. No. 12857

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN 1b <i>14 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2809 University Blvd. W.</i>				d. STREET ADDRESS <i>2809 University Blvd. West</i>			
3. NAME OF DECEASED (Type or print) <i>ELSIE</i> First Middle Last <i>WINKLER</i>				4. DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/14/92</i>	
9. AGE (In years last birthday) <i>68 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Christian Treffeisen</i>				14. MOTHER'S MAIDEN NAME <i>Maria Salomea Koch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hugo Winkler - 2809 Univ. Blvd. W. Kensington</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary failure</i> <i>154X</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of rectum</i> (c) <i>unknown</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>6 months</i> <i>unknown</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May, 1960</i> , to <i>Nov. 11, 1960</i> , that I last saw the deceased alive on <i>Nov. 10, 1960</i> , and that death occurred at <i>9 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eino Magi</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>918 University Blvd. E. Silver Spring, Md. 11/12/60</i>			
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>11/15/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, INC.</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 17 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12884 CERTIFICATE OF DEATH

12858

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 1			
3. NAME OF DECEASED (Type or print) First Paul Middle Millard Last Wolverton				4. DATE OF DEATH Month November Day 5 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1945		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Perry M. Wolverton				14. MOTHER'S MAIDEN NAME Mary Dutterer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Hepatitis, unknown etiology DUE TO (c) Pulmonary Aspergillosis							INTERVAL BETWEEN ONSET AND DEATH days months weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that m (this hospital) attended the deceased from October 16, 1960 to November 5, 1960 , that m (we) last saw the deceased alive on November 5, 1960 , and that death occurred at 8:46AM from the causes and on the date stated above.							
22a. SIGNATURE W. Anderson Spickard, Jr., M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/5/60	
22c. PHYSICIAN'S NAME (Type) W. Anderson Spickard, Jr., M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8 Nov 60		23c. NAME OF CEMETERY OR CREMATORY UNION		23d. LOCATION (City, town, or county) (State) LEESBURG Va	
24. FUNERAL DIRECTOR'S SIGNATURE Stanley Reed				25a. REC'D BY REGISTRAR DATE NOV 9 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

2251

1999

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

12859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Kinston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 55 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center		d. STREET ADDRESS 1006 Harvey Circle	
3. NAME OF DECEASED (Type or print) Jesse Pugh Wooten, Junior		4. DATE OF DEATH November 24 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1944
9. AGE (In years last birthday) 16		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Pugh Wooten, Senior		14. MOTHER'S MAIDEN NAME Harriett H. Tull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphatic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Week 1 Year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 30, 19 60 , to November 24, 19 60 , that I last saw the deceased alive on November 24, 19 60 , and that death occurred at 10:05 a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward E. Morse M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11-24-60	
PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-TRANSIT		22b. DATE THEREOF 11-24-60	
22c. NAME OF CEMETERY OR CREMATORY Bethesda, Md		22d. LOCATION (City, town, or county) (State) Kinston, N. CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS Bethesda, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12886

CERTIFICATE OF DEATH

12860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle B Last Young		4. DATE OF DEATH Month 11 Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ockershouser		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Thomas B. Young, Husband		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinomatosis DUE TO (c) metastatic adenocarcinoma of breast INTERVAL BETWEEN ONSET AND DEATH 3 months 2 1/2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 56 to Nov 10 , 19 60 and that death occurred at 10:15 A.M. , from the causes and on the date stated above. olive on Nov 10 , 19 60 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4890 Battery Lane Nov 19, '60 DATE SIGNED ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut M.D. Bethesda Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. A. Hume Co.		ADDRESS 2901 14th N.W.	
24a. REC'D BY REGISTRAR NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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George H. Baker

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701

CERTIFICATE OF DEATH

Reg. Dist. No.

12861

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Marilea Sanitarium ville Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGUERITE SLUYTER ZABRISKIE		4. DATE OF DEATH Nov. 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. B. Sluyter		14. MOTHER'S MAIDEN NAME Meintje Eleveld	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Myron L. Zabriskie, Rd., Greenbelt, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2, 1960 to Nov 5, 1960 that I last saw the deceased alive on Nov 5, 1960 and that death occurred at 12:34 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers M.D.		DATE SIGNED Nov 5, 1960	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		1919 Sweeney Rd., Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY South Church Cemetery		22d. LOCATION (City, town, or county) (State) Bergenfield New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland.		24a. REC'D BY REGISTRAR NOV 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

12301

CERTIFICATE OF DEATH

Montgomery County

Maryland

Prince George's

Silver Spring

Greenbelt

1951

Marilee Constance Vile Rose, 65 Reservoir Road

MARGUERITE BLUTER EASBICK

Female White

Oct. 1, 1888

Housewife At Home Green Belt, Maryland U.S.A.

John O. R. Bishop

Marilee Easbick

65 Reservoir

No Name Yes

Marilee Easbick, 65 Reservoir Rd., Greenbelt, Md.

JOHN A. ROGERS

1919 Reservoir Rd., Silver Spring, Md.

Serial Nov. 9, 1960 South Union Cemetery, Bethesda, Md.

W. V. DUNN & CO., Silver Spring, Maryland